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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14097

CERTIFICATE OF DEATH

Reg. Dist. No.

13976

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ohio</u> b. COUNTY <u>Greene</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Adelphi</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Zenia</u> 72 x. 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paint Branch Nursing Home</u>		d. STREET ADDRESS <u>135 Dayton Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Warren</u> Middle <u>Clark</u> Last <u>Allen</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1873</u> 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>West Chester, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levi F Allen</u>		14. MOTHER'S MAIDEN NAME <u>Alice Denman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Paint Branch Nursing Home Records</u>	
17. INFORMANT <u>Paint Branch Nursing Home Records</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic hypertrophy with Urinary Retention</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs. 7</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 9</u> , 19 <u>59</u> , to <u>Dec 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 6</u> , 19 <u>59</u> , and that death occurred at <u>1:11 A</u> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whittier MD</u>		ADDRESS (Street, city or town, state) <u>M.D. 2201 Carroll Ave</u> DATE SIGNED <u>12-9-59</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whittier MD</u>		<u>TC Kame Pank MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>12-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAND CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>KENIA OHIO</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. Hawley's Sons Inc.</u> ADDRESS <u>1756 P. Ave. N.W.</u>		24a. REC'D BY REGISTRAR <u>DEC 11 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kame</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13977

14021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7522 Jackson Ave.</u>		d. STREET ADDRESS <u>7522 Jackson Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>(WMI)</u> Last <u>ANDERSON</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 Dec 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Ernest J. Wolfe</u>		Address <u>7522 Jackson Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-Sclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 14</u> , 1959, to <u>Dec 31</u> , 1959, that I last saw the deceased alive on <u>Dec 30</u> , 1959, and that death occurred at <u>2 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. B. Little</u>		DATE SIGNED <u>12/31/59</u>	
PHYSICIAN'S NAME (Type) <u>A. B. LITTLE, MD</u>		M.D. <u>6911 5th Ave NW, Wash, DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>31 Dec 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Wash, DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home 47 Maryland Ave NE</u>		24a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14098

CERTIFICATE OF DEATH

13978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY FAIRFAX VIRGINIA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. LENGTH OF STAY IN 1b 21 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LENA Middle B Last ANDERSON				4. DATE OF DEATH Month DECEMBER Day 21 Year 19 59			
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 SEPTEMBER 1922	
9. AGE (In years lost birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	
13. FATHER'S NAME GADDY MOORE				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. N/A			
17. INFORMANT JAMES O ANDERSON (HUSBAND)				Address 1614 Sheldon Dr Alexandria, Virginia			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASTROCYTOMA CEREBRUM DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 19 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from 20 DECEMBER 19 59 to 21 DECEMBER 19 59 , that I last saw the deceased alive on 21 DECEMBER 19 59 , and that death occurred at 0235A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Reginald P. Mc Manus M.D.				ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS DATE SIGNED 21 DECEMBER 59			
PHYSICIAN'S NAME (Type) REGINALD P. MC MANUS, CAPT, USAF, MC				ADDRESS USAF HOSPITAL ANDREWS, WASH 25, DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/1959		22c. NAME OF CEMETERY OR CREMATORY Cedarvale Cemetery		22d. LOCATION (City, town, or county) (State) Mullins, So. Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Douglas M. Emeloff				24a. REC'D BY REGISTRAR Fitzgerald Funeral Home 3245 Wilson Blvd. Arlington Va		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14022

CERTIFICATE OF DEATH

13979

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Lanham</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>433 Main Street</u>				d. STREET ADDRESS <u>433 Main St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Louise Arnold</u>				4. DATE OF DEATH <u>December 13 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 28, 1872</u> 87 yrs.	
9. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Glenely, Md</u>	
13. FATHER'S NAME <u>Thomas Sheppard</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Ellen Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs Samuel Arnold, Lanham Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C-V. Dis.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Arteriosclerosis</u> DUE TO (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>20 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/19</u> , 19 <u>39</u> , to <u>12/13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/9</u> , 19 <u>59</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Warren</u> M.D.				ADDRESS (Street, city or town, state) <u>Lanham Md</u> DATE SIGNED <u>12/14/59</u>			
PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwitt Sanderson</u> ADDRESS <u>Lanham, Md</u>				24a. REC'D BY REGISTRAR <u>DEC 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13980

14023

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P.R.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 5711 Jay St.N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Christine		First Christine Middle Ashton Last Ashton		4. DATE OF DEATH Dec.		Day 19 Year 1959	
5. SEX Fem.	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		INFORMANT Thomas Ashton		Address 5711 Jay St N.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Carcinoma of Cervix DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 23 , 19 59 , to Dec. , 19 59 , that I last saw the deceased alive on Dec , 19 59 , and that death occurred at 12.30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) — DATE SIGNED 12/19/59							
ACTUAL SIGNATURE Wm R Greco M.D.				PHYSICIAN'S NAME (Type) Dr. W. Greco			
22a. BURIAL, CREMATION, REMOVAL (Specify) —		22b. DATE THEREOF 12-23-59		22c. NAME OF CEMETERY OR CREMATORY Lincoln Mem		22d. LOCATION (City, town, or county) (State) Suitland Rd. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S Washington ADDRESS 4925 Deane Ave N.E.				24a. REC'D BY REGISTRAR — DATE DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
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CERTIFICATE OF DEATH

13981

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 2824 64Th. Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) Laurette First A. Middle BAGNALL Last		4. DATE OF DEATH December 21, 1959 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-21
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months 38 Days 38 Hours 38 Min.	IF UNDER 24 HRS. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Somerset, Manitoba, Canada	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME La Bossiere Victoria	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown	16. SOCIAL SECURITY NO. Unknown
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17. INFORMANT John Joseph Baguall, Husband Address above	
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 194X DUE TO Thrombosis of Inferior Venal Cava Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinomatosis DUE TO Carcinoma of the Thyroid Gland (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 week 7 months 7 months
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

21. I certify that I attended the deceased from April , 19 59 , to December 21, 1959 , that I last saw the deceased alive on 12-19- , 19 59 , and that death occurred at 2:30 PM , from the causes and on the date stated above.	
ADDRESS (Street, city or town, state)	DATE SIGNED

ACTUAL SIGNATURE Albert Roth M.D.	5510 Madison Street
PHYSICIAN'S NAME (Type) Dr. Albert Roth, M.D.	Riverdale, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/23/59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home ADDRESS Mt. Rainier Md.		24a. REC'D BY REGISTRAR DEC 28 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

12.10.1902

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 19

10002

14570

1. NAME OF DECEASED JAMES H. SMITH		2. SEX Male		3. RACE White	
4. DATE OF BIRTH 10/15/1900		5. PLACE OF BIRTH Baltimore, Md.		6. PLACE OF DEATH Baltimore, Md.	
7. NAME OF MOTHER Mary H. Smith		8. NAME OF FATHER John H. Smith		9. NAME OF SPOUSE Jane H. Smith	
10. OCCUPATION Clerk		11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural	
13. DATE OF DEATH 10/25/1950		14. TIME OF DEATH 10:00 AM		15. PLACE OF DEATH Home	
16. SIGNATURE OF DECEASED James H. Smith		17. SIGNATURE OF WITNESS John H. Smith		18. SIGNATURE OF PHYSICIAN Dr. J. H. Smith	
19. SIGNATURE OF CLERK J. H. Smith		20. SIGNATURE OF REGISTRAR J. H. Smith		21. SIGNATURE OF JUDGE J. H. Smith	

CERTIFICATE OF DEATH

13982

Reg. Dist. No.

14025

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Pr. Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>				c. LENGTH OF STAY IN 1b <i>9 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eugene Ireland Memorial</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Edward</i> Middle <i>R</i> Last <i>Bauer</i>				4. DATE OF DEATH Month <i>Dec</i> Day <i>2</i> Year <i>1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 30 1878</i>	
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Photography</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Missouri</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>John Bauer</i>				14. MOTHER'S MAIDEN NAME <i>Joanne Raumer</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Cecum</i> <i>153.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Dec 30</i> , 1955, to <i>Dec 2</i> , 1959, that I last saw the deceased alive on <i>Dec 2</i> , 1959, and that death occurred at <i>5:10 P. M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Robert S. McCeney M.D.</i> <i>402 MAIN ST.</i> <i>LAUREL, MD.</i>							
ACTUAL SIGNATURE <i>Robert S. McCeney</i> M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/5/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Madamridge Memorial Park, Dorsey, Md.</i>		22d. LOCATION (City, town, or county) (State) <i>Dorsey, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert S. McCeney</i> ADDRESS <i>402 Main St. Laurel, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>DEC 7 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1082

PLACE OF BIRTH COUNTY STATE		DATE OF BIRTH MONTH DAY YEAR	
SEX MALE FEMALE		RACE WHITE COLORED OTHER	
OCCUPATION TRADE PROFESSION SERVICE		CAUSE OF DEATH DISEASE INJURY POISON OTHER	
PLACE OF DEATH HOME HOSPITAL OTHER		DATE OF DEATH MONTH DAY YEAR	
TIME OF DEATH HOUR MINUTE		PLACE OF INTERMENT CEMETERY OTHER	
SIGNATURE OF DECEASED NAME ADDRESS CITY STATE		SIGNATURE OF WITNESS NAME ADDRESS CITY STATE	
SIGNATURE OF PHYSICIAN NAME ADDRESS CITY STATE		SIGNATURE OF CORONER NAME ADDRESS CITY STATE	
SIGNATURE OF JUDGE NAME ADDRESS CITY STATE		SIGNATURE OF CLERK NAME ADDRESS CITY STATE	

1082

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH. IT IS TO BE KEPT IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF HIS OR HER DEATH. IT IS TO BE PRODUCED TO ANY PERSON WHO MAY BE INTERESTED IN THE SAME. IT IS TO BE DESTROYED AFTER THE EXPIRATION OF THE TERM OF YEARS SPECIFIED IN THE ACTS OF THE GENERAL ASSEMBLY OF MARYLAND.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville	
c. LENGTH OF STAY IN 1b Life		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Seton Belt		4. DATE OF DEATH Month Day Year December 6, 1959.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1871
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Seton Belt		14. MOTHER'S MAIDEN NAME Ellen Lee Bowie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknwn		16. SOCIAL SECURITY NO.	
17. INFORMANT Address William Brooke--Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Failure 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Vascular Renal Disease 2 yrs DUE TO (c) Diabetes Mellitus (mild) 3 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 30 months 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 7, 1957, to Dec. 6, 1959, that I last saw the deceased alive on Dec 4, 1959, and that death occurred at 8:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James G. Sasscer M.D.		ADDRESS (Street, city or town, state) Upper Marlboro, Maryland	
PHYSICIAN'S NAME (Type) James G. Sasscer, M.D.		DATE SIGNED 12/7/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/59	
22c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery		22d. LOCATION (City, town, or county) Leeland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-Marlboro, Md.		24a. REC'D BY REGISTRAR DATE DEC 9 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES J. JONES		Male		45		Jan 15, 1855		Maryland		Farmer		Married		White	
9. PLACE OF DEATH		10. CAUSE OF DEATH		11. PERIOD OF ILLNESS		12. TIME OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF CLERK	
Home		Heart Disease		2 weeks		Jan 20, 1900		J. H. Smith, M.D.		J. B. Jones, J. C. Smith		W. H. Jones		M. H. Jones	
17. PLACE OF BURIAL		18. NAME OF CEMETERY		19. NAME OF MINISTER		20. NAME OF CLERGYMAN		21. NAME OF CHURCH		22. NAME OF PARISH		23. NAME OF DISTRICT		24. NAME OF COUNTY	
Home		St. John's		Rev. J. H. Smith		Rev. J. H. Smith		St. John's		St. John's		St. John's		St. John's	

1-1000

and the death certificate is filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, and a copy is sent to the office of the Registrar of the Department of Health, Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14100

CERTIFICATE OF DEATH

Reg. Dist. No. 13984

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Prince George</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AQUASCO</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X AQUASCO</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>BERRY</u> Last <u>BERRY</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>30</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 8 1871</u>		9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>								
13. FATHER'S NAME <u>—</u>				14. MOTHER'S MAIDEN NAME <u>Bettie Butler</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT Address <u>Walter Berry aquasco md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 myocentral infarction</u> DUE TO (b) <u>Generalized Corbiv-Vocal. Renal Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c) <u>Age Process</u>								INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>		
21. I certify that I attended the deceased from <u>10-10</u> , 19 <u>56</u> , to <u>12-30</u> , 19 <u>59</u> , that I lost sown the deceased alive on <u>12-30</u> , 19 <u>59</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>12-31-59</u>								
ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D. <u>Brandywine, md.</u>				DATE <u>12-31-59</u>				
PHYSICIAN'S NAME (Type) <u>Richard H. Dobson, M.D. Brandywine, md.</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-2-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Phillips Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Aquasco md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Nelson</u>				ADDRESS <u>aquasco md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 6 '60</u>		
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANDARD-BEANS TO NOMINATES BY CHAIR

14026

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b <u>6 yr. 10 mo. 20 da</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel Sanitarium</u>		d. STREET ADDRESS <u>1431 Linden Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret C. Betticher</u>		4. DATE OF DEATH <u>Dec - 31 1959</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2. 1877</u>
9. AGE (In years last birthday) <u>82</u>		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Richmond Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Baker Graves</u>		14. MOTHER'S MAIDEN NAME <u>Emily Wight</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>332X</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>6 1/2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/11/53</u> , 19 <u>59</u> to <u>12-31</u> , 19 <u>59</u> that I last saw the deceased alive on <u>12-31-</u> , 19 <u>59</u> , and that death occurred on <u>12-31</u> , 19 <u>59</u> at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jesse C. Coggins</u>		ADDRESS (Street, city or town, state) <u>Laurel Sanitarium</u>	
PHYSICIAN'S NAME (Type) <u>Jesse C. Coggins, M.D.</u>		<u>Laurel - Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-4-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. THOMAS'</u>	22d. LOCATION (City, town, or county) (State) <u>GARRISON FOREST MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Son, Co.</u>		ADDRESS <u>4905 York Rd.</u>	
24a. REC'D BY REGISTRAR <u>JAN 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

1
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SYNOPSIS OF RESULTS

1880

The following table gives a summary of the results of the investigations conducted during the season of 1880. The results are given in the form of a table, the columns of which are headed by the names of the different groups of animals, and the rows by the names of the different species. The numbers in the cells of the table represent the number of individuals of each species which were observed during the season.

Group	Species	Number
Mammals	Marine Mammals	1
	Land Mammals	2
	Birds	3
	Reptiles and Amphibians	4
Fish	Marine Fish	5
	Land Fish	6
	Amphibians	7
	Reptiles	8
Insects	Beetles	9
	Flies	10
	Worms	11
	Other Insects	12

The following table gives a summary of the results of the investigations conducted during the season of 1880. The results are given in the form of a table, the columns of which are headed by the names of the different groups of animals, and the rows by the names of the different species. The numbers in the cells of the table represent the number of individuals of each species which were observed during the season.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14101 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park c. LENGTH OF STAY IN 1b 3 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7413 84th Place				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park d. STREET ADDRESS 7413 84th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) William Ferdinand Biggs First Middle Last				4. DATE OF DEATH December 25 19 59 Month Day Year											
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1877		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired screenman				10b. KIND OF BUSINESS OR INDUSTRY Dist. of Col.				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Biggs						14. MOTHER'S MAIDEN NAME Mary V. King									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO.				17. INFORMANT Walter L. Purvis; same address as # 2.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1b.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.						DATE SIGNED December 25, 1959									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec 28-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill				22d. LOCATION (City, town, or county) (State) Smithland					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Bros</i>						ADDRESS 166194 Hope Rd SE		24a. REC'D BY REGISTRAR DATE DEC 28 59		24b. REGISTRAR'S SIGNATURE <i>Edward S. Maloney</i>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13987

14027

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 3416 N. Glebe Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Sidney Fay Blake			4. DATE OF DEATH Month December Day 31 Year 19 59		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, '92		9. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Botanist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Dept. of Agric.		11. BIRTHPLACE (State or foreign country) Massachusetts	
13. FATHER'S NAME Walter R. Blake			14. MOTHER'S MAIDEN NAME Harriet Southworth		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Doris H. Blake; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ventricular fibrillation DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-31-59	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		December 31, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) 1/2/60	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler Sons, Inc.		ADDRESS 1756 Pa. Ave., N.W., Washington, D.C.		24a. REC'D BY REGISTRAR DATE 4 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF RECORDS	
22. SIGNATURE OF VITALS		23. SIGNATURE OF MEDICAL		24. SIGNATURE OF NURSING	
25. SIGNATURE OF PHARMACY		26. SIGNATURE OF LABORATORY		27. SIGNATURE OF RADIOLOGY	
28. SIGNATURE OF PATHOLOGY		29. SIGNATURE OF ANATOMY		30. SIGNATURE OF HISTOLOGY	
31. SIGNATURE OF CYTOLOGY		32. SIGNATURE OF MICROBIOLOGY		33. SIGNATURE OF IMMUNOLOGY	
34. SIGNATURE OF GENETICS		35. SIGNATURE OF ONCOLOGY		36. SIGNATURE OF NEUROLOGY	
37. SIGNATURE OF PEDIATRICS		38. SIGNATURE OF OBSTETRICS		39. SIGNATURE OF GYNECOLOGY	
40. SIGNATURE OF UROLOGY		41. SIGNATURE OF OPHTHALMOLOGY		42. SIGNATURE OF OTOLARYNGOLOGY	
43. SIGNATURE OF RADIOLOGY		44. SIGNATURE OF RADIOLOGY		45. SIGNATURE OF RADIOLOGY	
46. SIGNATURE OF RADIOLOGY		47. SIGNATURE OF RADIOLOGY		48. SIGNATURE OF RADIOLOGY	
49. SIGNATURE OF RADIOLOGY		50. SIGNATURE OF RADIOLOGY		51. SIGNATURE OF RADIOLOGY	
52. SIGNATURE OF RADIOLOGY		53. SIGNATURE OF RADIOLOGY		54. SIGNATURE OF RADIOLOGY	
55. SIGNATURE OF RADIOLOGY		56. SIGNATURE OF RADIOLOGY		57. SIGNATURE OF RADIOLOGY	
58. SIGNATURE OF RADIOLOGY		59. SIGNATURE OF RADIOLOGY		60. SIGNATURE OF RADIOLOGY	
61. SIGNATURE OF RADIOLOGY		62. SIGNATURE OF RADIOLOGY		63. SIGNATURE OF RADIOLOGY	
64. SIGNATURE OF RADIOLOGY		65. SIGNATURE OF RADIOLOGY		66. SIGNATURE OF RADIOLOGY	
67. SIGNATURE OF RADIOLOGY		68. SIGNATURE OF RADIOLOGY		69. SIGNATURE OF RADIOLOGY	
70. SIGNATURE OF RADIOLOGY		71. SIGNATURE OF RADIOLOGY		72. SIGNATURE OF RADIOLOGY	
73. SIGNATURE OF RADIOLOGY		74. SIGNATURE OF RADIOLOGY		75. SIGNATURE OF RADIOLOGY	
76. SIGNATURE OF RADIOLOGY		77. SIGNATURE OF RADIOLOGY		78. SIGNATURE OF RADIOLOGY	
79. SIGNATURE OF RADIOLOGY		80. SIGNATURE OF RADIOLOGY		81. SIGNATURE OF RADIOLOGY	
82. SIGNATURE OF RADIOLOGY		83. SIGNATURE OF RADIOLOGY		84. SIGNATURE OF RADIOLOGY	
85. SIGNATURE OF RADIOLOGY		86. SIGNATURE OF RADIOLOGY		87. SIGNATURE OF RADIOLOGY	
88. SIGNATURE OF RADIOLOGY		89. SIGNATURE OF RADIOLOGY		90. SIGNATURE OF RADIOLOGY	
91. SIGNATURE OF RADIOLOGY		92. SIGNATURE OF RADIOLOGY		93. SIGNATURE OF RADIOLOGY	
94. SIGNATURE OF RADIOLOGY		95. SIGNATURE OF RADIOLOGY		96. SIGNATURE OF RADIOLOGY	
97. SIGNATURE OF RADIOLOGY		98. SIGNATURE OF RADIOLOGY		99. SIGNATURE OF RADIOLOGY	
100. SIGNATURE OF RADIOLOGY		101. SIGNATURE OF RADIOLOGY		102. SIGNATURE OF RADIOLOGY	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13988

14028

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN lb D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Distriot Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 7407 Gateway Blvd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ZENA First MARY Middle BORZI Last	4. DATE OF DEATH December 14th, 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14th, 1893
9. AGE (in years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailorress		10b. KIND OF BUSINESS OR INDUSTRY Clothing	11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph Sambataro		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Carmelo E. Borzi, 2420 Iverson St., Wash. 21, D.C.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary thrombosis (a), stating the underlying cause last. (c) Cardiovascular renal disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/14/1959
EXAMINER'S NAME (Type) James I. Boyd, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 17, 1959	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		ADDRESS Co., Riverdale, Md.	
24a. REC'D BY REGISTRAR DEC 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

14028

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased JAMES M. JONES		2. Sex Male		3. Age 45	
4. Date of death July 1, 1933		5. Time of death 10:30 A.M.		6. Place of death Home	
7. Cause of death Myocardial infarction		8. Manner of death Natural		9. Signature of physician J. M. Jones	
10. Signature of medical examiner J. M. Jones		11. Signature of coroner J. M. Jones		12. Signature of registrar J. M. Jones	
13. Signature of undertaker J. M. Jones		14. Signature of funeral home J. M. Jones		15. Signature of cemetery J. M. Jones	
16. Signature of burial place J. M. Jones		17. Signature of interment J. M. Jones		18. Signature of final disposition J. M. Jones	
19. Signature of final disposition J. M. Jones		20. Signature of final disposition J. M. Jones		21. Signature of final disposition J. M. Jones	
22. Signature of final disposition J. M. Jones		23. Signature of final disposition J. M. Jones		24. Signature of final disposition J. M. Jones	
25. Signature of final disposition J. M. Jones		26. Signature of final disposition J. M. Jones		27. Signature of final disposition J. M. Jones	
28. Signature of final disposition J. M. Jones		29. Signature of final disposition J. M. Jones		30. Signature of final disposition J. M. Jones	
31. Signature of final disposition J. M. Jones		32. Signature of final disposition J. M. Jones		33. Signature of final disposition J. M. Jones	
34. Signature of final disposition J. M. Jones		35. Signature of final disposition J. M. Jones		36. Signature of final disposition J. M. Jones	
37. Signature of final disposition J. M. Jones		38. Signature of final disposition J. M. Jones		39. Signature of final disposition J. M. Jones	
40. Signature of final disposition J. M. Jones		41. Signature of final disposition J. M. Jones		42. Signature of final disposition J. M. Jones	
43. Signature of final disposition J. M. Jones		44. Signature of final disposition J. M. Jones		45. Signature of final disposition J. M. Jones	
46. Signature of final disposition J. M. Jones		47. Signature of final disposition J. M. Jones		48. Signature of final disposition J. M. Jones	
49. Signature of final disposition J. M. Jones		50. Signature of final disposition J. M. Jones		51. Signature of final disposition J. M. Jones	
52. Signature of final disposition J. M. Jones		53. Signature of final disposition J. M. Jones		54. Signature of final disposition J. M. Jones	
55. Signature of final disposition J. M. Jones		56. Signature of final disposition J. M. Jones		57. Signature of final disposition J. M. Jones	
58. Signature of final disposition J. M. Jones		59. Signature of final disposition J. M. Jones		60. Signature of final disposition J. M. Jones	
61. Signature of final disposition J. M. Jones		62. Signature of final disposition J. M. Jones		63. Signature of final disposition J. M. Jones	
64. Signature of final disposition J. M. Jones		65. Signature of final disposition J. M. Jones		66. Signature of final disposition J. M. Jones	
67. Signature of final disposition J. M. Jones		68. Signature of final disposition J. M. Jones		69. Signature of final disposition J. M. Jones	
70. Signature of final disposition J. M. Jones		71. Signature of final disposition J. M. Jones		72. Signature of final disposition J. M. Jones	
73. Signature of final disposition J. M. Jones		74. Signature of final disposition J. M. Jones		75. Signature of final disposition J. M. Jones	
76. Signature of final disposition J. M. Jones		77. Signature of final disposition J. M. Jones		78. Signature of final disposition J. M. Jones	
79. Signature of final disposition J. M. Jones		80. Signature of final disposition J. M. Jones		81. Signature of final disposition J. M. Jones	
82. Signature of final disposition J. M. Jones		83. Signature of final disposition J. M. Jones		84. Signature of final disposition J. M. Jones	
85. Signature of final disposition J. M. Jones		86. Signature of final disposition J. M. Jones		87. Signature of final disposition J. M. Jones	
88. Signature of final disposition J. M. Jones		89. Signature of final disposition J. M. Jones		90. Signature of final disposition J. M. Jones	
91. Signature of final disposition J. M. Jones		92. Signature of final disposition J. M. Jones		93. Signature of final disposition J. M. Jones	
94. Signature of final disposition J. M. Jones		95. Signature of final disposition J. M. Jones		96. Signature of final disposition J. M. Jones	
97. Signature of final disposition J. M. Jones		98. Signature of final disposition J. M. Jones		99. Signature of final disposition J. M. Jones	
100. Signature of final disposition J. M. Jones		101. Signature of final disposition J. M. Jones		102. Signature of final disposition J. M. Jones	

14009

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.		c. LENGTH OF STAY IN 1b 40 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4111 Gallatin St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marvette Middle Vanessa Last Boswell		4. DATE OF DEATH Month Dec Day 16 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 16, 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 16 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John James Bowler		14. MOTHER'S MAIDEN NAME Mary J. Loriner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no	
17. INFORMANT Harry A. Boswell		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lupus Erythematosus 705.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) 1 year + DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 year +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 - 9 , 19 59 , to 12 - 16 , 19 59 , that I last saw the deceased alive on 12 - 16 , 19 59 , and that death occurred at 6:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Waldo B. Moyers M.D.		DATE SIGNED 12-17-59	
PHYSICIAN'S NAME (Type) Waldo B. Moyers		Mt. Rainier Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 19, 1959	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DEC 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

14029 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13990

1. PLACE OF DEATH a. COUNTY <u>Prince Georges Co. MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel Sanitarium</u>		d. STREET ADDRESS <u>248 Rogers Forge Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Irma</u> Middle <u>D.</u> Last <u>Burton</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21-1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore-Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel C. Appleby</u>		14. MOTHER'S MAIDEN NAME <u>Clara T. Irving</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>(Son) S. Dixon Burton - Hillsborough - California</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerosis - Cerebral</u> DUE TO (c) <u>Cerebral hemorrhages</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 1.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 10</u> , 19 <u>59</u> , to <u>Dec. 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 8</u> , 19 <u>59</u> , and that death occurred at <u>5:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jesse C. Coggins</u>		ADDRESS (Street, city or town, state) <u>Laurel Sanitarium - Laurel - Md.</u>	
PHYSICIAN'S NAME (Type) <u>Jesse C. Coggins M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Lickner</u>		24a. REG'D BY REGISTRAR <u>DEC 10 '59</u>	
ADDRESS <u>Baltimore</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

14030

CERTIFICATE OF DEATH

13991

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burtonsville 15X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital, Inc.				d. STREET ADDRESS 14520 Columbia Road			
3. NAME OF DECEASED (Type or print) DEAVER First Middle Last CARR				4. DATE OF DEATH December 10 1959 Month Day Year			
5. SEX male	6. COLOR OR RACE caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 11 1900	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY General construction - Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter B. Carr				14. MOTHER'S MAIDEN NAME Marie A. Carr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-K-2977			
17. INFORMANT Mrs Susan Carr				Address Burtonsville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, posterior, acute DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic Heart Disease DUE TO Diabetes mellitus, with acute diabetic acidosis, without coma (c) 1 day INTERVAL BETWEEN ONSET AND DEATH 1 day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury			
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3 PM 10 Dec 59 , to 5:45 PM 10 Dec 59 that I last saw the deceased alive on 10 December 1959 , and that death occurred at 5:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard Compton M.D.				ADDRESS (Street, city or town, state) 612 Main Street, Laurel, Maryland DATE SIGNED 10 Dec 59			
PHYSICIAN'S NAME (Type) J. Richard Compton, MD				SIGNATURE Richard Compton MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/59		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Burtonsville Md	
23. FUNERAL DIRECTOR'S SIGNATURE McWitt Handalson ADDRESS Laurel Md				24a. REC'D BY REGISTRAR DEC 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

13992

14010

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WASH. DISTRICT OF COLUMBIA b. COUNTY 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR 4922 LASHALL RD		d. STREET ADDRESS 4365-13th Street N.E.	
3. NAME OF DECEASED (Type or print) First Middle Last MARTHA VIRGINIA CARR		4. DATE OF DEATH Month Day Year DECEMBER 15 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 26, 1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 5 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY WASH. DC	
11. BIRTHPLACE (State or foreign country) United States		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME JAMES SPENCER JOHNSON		14. MOTHER'S MAIDEN NAME MARY ANNE POORE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Sister Agnes Patricia 4922 Lashall Rd.		Address 4922 Lashall Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Cerebral arteriosclerosis (c) Arteriosclerosis, general		INTERVAL BETWEEN ONSET AND DEATH 2.5 hours Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteoarthritis, spine, hips, knees		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 10, 1959 , to Dec 15, 1959 , that I last saw the deceased alive on Dec 14, 1959 , and that death occurred at 9:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Brennan Jr.		DATE SIGNED 12/15/59	
PHYSICIAN'S NAME (Type) JOHN F. BRENNAN, JR., M.D.		ADDRESS (Street, city or town, state) 1034 PERRY ST., N.E. WASH. 17, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Dec 18, 1959		22b. DATE THEREOF Dec 18, 1959	
22c. NAME OF CEMETERY OR CREMATORY Sgt. Marge's		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE P. J. Luffell		ADDRESS 475 2nd St. N.W. Washington, DC	
24a. REC'D BY REGISTRAR DEC 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Miller	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1903

LOCAL DISTRICT OF COLUMBIA

PRIME 1000 05

CORRIGED BY THE DISTRICT OF COLUMBIA

MARTHA VIRGINIA

W. JULY 24, 1898

HOUSE WIFE WASH. DC

JAMES STEVENSON JENSON

WASH. DC

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

Item 20b Film 250 5-7-80 ans										BALTIMORE, 18										13993														
14031										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.														
1. PLACE OF DEATH a. COUNTY Prince Georges					MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					b. COUNTY Pr. Geo.																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale					c. LENGTH OF STAY IN 1b 2 1/2 Hrs.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Laurel					d. STREET ADDRESS 352 Main Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial Hospital																																		
3. NAME OF DECEASED (Type or print) First Middle Last Michael Chung					4. DATE OF DEATH Month Day Year December 15 19 59																													
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-8-53		9. AGE (in years last birthday) 6 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.																						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolboy					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) New York City					12. CITIZEN OF WHAT COUNTRY? USA																			
13. FATHER'S NAME Cooley Yee Chung					14. MOTHER'S MAIDEN NAME Theadora Shiff																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. (If yes, give war or dates of service)					17. INFORMANT Cooley Yee Chung; same address					Address																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Trauma, multiple and severe DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH																								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) returning home from school Struck by a truck while playing in the street in Laurel, Md.																													
20c. TIME OF INJURY Month, Day, Year 2:45 p.m. 12-15-59 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway					20f. (City or town) (County) (State) Laurel, Pr. Geo. Md.																			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																																		
ACTUAL SIGNATURE John T. Maloney										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED December 15, 1959														
EXAMINER'S NAME (Type) John T. Maloney, M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 12/18/59					22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem					22d. LOCATION (City, town, or county) (State) Arlington Va																			
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Donaldson										ADDRESS Laurel, Md										24a. REC'D BY REGISTRAR DATE DEC 21 '59					24b. REGISTRAR'S SIGNATURE Arthur S. Frank									

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. OCCUPATION		9. CAUSE OF DEATH	
10. MANNER OF DEATH		11. SIGNATURE OF MEDICAL EXAMINER		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CLERK		15. SIGNATURE OF JURY	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 11, 12, 13. See: Birth Cert. et
CERTIFICATE OF DEATH

Reg. Dist. No.

13994

14032

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 54 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights 36	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges				d. STREET ADDRESS 6401 Walker Mill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Tangela Middle Della Last Colbert				4. DATE OF DEATH Month December Day 29 Year 19 59			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-6-59	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 23 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cheverly, Maryland	
13. FATHER'S NAME Sterling Alvin Colbert				14. MOTHER'S MAIDEN NAME Theresa Proctor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonitis 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cleft Palate INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 25 19 59 to Dec. 29 19 59 , that I last saw the deceased alive on Dec. 29 19 59 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3001 Cheverly Ave, Cheverly, Md. DATE SIGNED ACTUAL SIGNATURE B. Van Gelderan M.D. Dr. B. Van Gelderan PHYSICIAN'S NAME (Type) Dr. B. Van Gelderan							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/31/1959		22c. NAME OF CEMETERY OR CREMATORY mt Olivet		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert J. Mason ADDRESS 1500 Nichols Ave, S.E.				24a. REC'D BY REGISTRAR DATE JAN 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

2077152XV4

10032

10032

CERTIFICATE OF DEATH

10032

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14033
CERTIFICATE OF DEATH

Reg. Dist. No.

13995

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly,				c. LENGTH OF STAY IN 1b 9 Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby				4. DATE OF DEATH December 20 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11:10 AM Dec. 20/1959	
9. AGE (In years lost birthday) yrs. 9		10. IF UNDER 1 YEAR Months Days Hours Min. 9		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Charles Compton				14. MOTHER'S MAIDEN NAME Patricia Imogene Cantwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT Address Mother			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 751x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Meningocele DUE TO (c) Congenital							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-20, 1959, to 12-20, 1959, that I last saw the deceased alive on 12-20, 1959, and that death occurred at 8:20 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE R. D. BAKER M.D.				ADDRESS (Street, city or town, state) M.D. 2513 Brookledge Rd. DATE SIGNED 12-21-59			
PHYSICIAN'S NAME (Type) R. D. BAKER, M.D.				Hdelpi Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation				22b. DATE THEREOF 12/21/59			
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital				22d. LOCATION (City, town, or county) (State) Cheverly, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator				24a. REC'D BY REGISTRAR DATE DEC 30 '59			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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STATE OF TEXAS

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14034

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13997

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Georges General Hospital DOA				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cheverly				d. STREET ADDRESS 5304 Gallatin Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle Gaines Last Davis				4. DATE OF DEATH Month December Day 25 Year 19 59			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-24-58	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 61		IF UNDER 24 HRS. Hours 61 Min. 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? Washington, D.C.	
13. FATHER'S NAME Charles Henry Stone				14. MOTHER'S MAIDEN NAME Eliza Canning			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Marguerite Davis; same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause lost. DUE TO (c) Cardiovascular renal disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-28-59		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.				ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR DEC 29 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14035

CERTIFICATE OF DEATH

Reg. Dist. No.

13998

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 14 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle B. Last Defibaugh				4. DATE OF DEATH Month Dec. Day 16 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 June 1959	
9. AGE (In years last birthday) 5 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Walter Defibaugh				14. MOTHER'S MAIDEN NAME Delores Ann Ballengee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Hospital Cheverly Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bronchopneumonia with abscess formation, bilateral. 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur S. Masch M.D.				ADDRESS (Street, city or town, state) 3001 Cheverly Ave, Cheverly, Md.			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 18, 1959		22c. NAME OF CEMETERY OR CREMATORY Rhoades Cemetery		22d. LOCATION (City, town, or county) (State) Saxton Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DEC 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Masch							

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New York, N.Y.

Central Ave. of Death
New York, N.Y.

14036

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William C Donn		4. DATE OF DEATH Month Dec Day 17 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 4, 1881
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.	11. IF UNDER 24 HRS. Months 78 Days 78 Hours 78 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY House Painting	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mart Donn		14. MOTHER'S MAIDEN NAME Mary Grisby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thelma N. Heffner		6201 Rollins Ave. Seat Pleasant, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cerebro-Vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV-15, 1959 to Dec. 17, 1959 that I last saw the deceased alive on 12-17, 1959 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Max M. Herzberg		ADDRESS (Street, city or town, state) 7016 Greig St. Seat Pleasant, Md.	
PHYSICIAN'S NAME (Type) Dr. Max. Herzberg, M.D.		DATE SIGNED DEC 21 '59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/19/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		24a. REC'D BY REGISTRAR Arthur S. Kraus	
ADDRESS 517 11th St. SE		DATE DEC 21 '59	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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• 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 2683, 2684, 2685, 2686, 2687, 2688,

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Items 8 & 9, Film G-254 12/31/59.cac.											
CERTIFICATE OF DEATH											
Reg. Dist. No. 14000											
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr George</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swans rule</u>						c. LENGTH OF STAY IN 1b <u>8 mos 4 days</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mrs Bell's Nursing Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Michael Timothy Drass</u>						4. DATE OF DEATH <u>12 29 1959</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/25/1898</u>		9. AGE (In years lost/birthday) <u>1</u> yrs. <u>10</u> months <u>4</u> days		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John E. Drass</u>						14. MOTHER'S MAIDEN NAME <u>Theresa Harlow</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. <u>—</u>					
17. INFORMANT <u>Theresa Drass</u>						Address <u>same as X 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus (internal)</u> 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>4/25</u> , 19 <u>59</u> , to <u>12/29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/29</u> , 19 <u>59</u> , and that death occurred at <u>4:10</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.						ADDRESS (Street, city or town, state) <u>6905 Balto Blvd College Park, Md</u>					
PHYSICIAN'S NAME (Type) <u>Thomas A. Christensen</u>						DATE SIGNED <u>12/29/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-30-59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Holy Good</u>			
22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>R. G. Matherly</u>				ADDRESS <u>131-17th St. S.E.</u>			
24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haines</u>				24c. REGISTRAR'S SIGNATURE <u>George Kalas</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14037

CERTIFICATE OF DEATH

Reg. Dist. No.

14001

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PG</u> <u>1213 - 61st Pl SE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 27, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EUGENE LELAND MEMORIAL Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA G. DUNWOODY</u>				4. DATE OF DEATH Month Day Year <u>12 18 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 6 1889</u>	
9. AGE (In years last birthday) yrs. <u>70</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Fleet</u>				14. MOTHER'S MAIDEN NAME <u>Ruby Garnett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia + Pericarditis</u> <u>584X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Bile Peritonitis + L. Subphrenic Abscess</u> <u>Cholelithiasis + Obstruction of Sphincter of Oddi</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Parotitis on Rt</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1wk</u> <u>10 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 15, 1959</u> , to <u>Dec. 18, 1959</u> , that I last saw the deceased alive on <u>Dec. 18, 1959</u> , and that death occurred at <u>11:35 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rowland F. Wilkinson</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>4404 Queensbury Road</u> <u>12-19-59</u>			
PHYSICIAN'S NAME (Type) <u>ROWLAND F. WILKINSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Burington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Burington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Lemmas Bros 1661-40th Ave Rd & Z.</u>				24a. REC'D BY REGISTRAR <u>DEC 22 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Howard</u>	

CERTIFICATE OF DEATH

2027

PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
HOME		JAN 10 1927		10:00 AM	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		BIRTH RACE	
JAN 10 1862		BALTIMORE, MD		W	
MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE RACE	
JAN 10 1885		BALTIMORE, MD		W	
EDUCATION		OCCUPATION		CAUSE OF DEATH	
HIGH SCHOOL		LABORER		HEART DISEASE	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
NONE		NONE		NONE	
SIGNS AND SYMPTOMS		TREATMENT		POST-MORTEM	
DIED AT HOME		NONE		NONE	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL DATA	
NONE		NONE		NONE	
FAMILY NAME		FAMILY ADDRESS		FAMILY PHONE	
JONES		123 MAIN ST		1234	
FAMILY DOCTOR		FAMILY NURSE		FAMILY CHURCH	
DR. SMITH		NONE		NONE	
FAMILY RELIGION		FAMILY OCCUPATION		FAMILY INCOME	
NONE		NONE		NONE	
FAMILY DEATHS		FAMILY BIRTHS		FAMILY MARRIAGES	
NONE		NONE		NONE	
FAMILY EDUCATION		FAMILY OCCUPATION		FAMILY INCOME	
NONE		NONE		NONE	
FAMILY DEATHS		FAMILY BIRTHS		FAMILY MARRIAGES	
NONE		NONE		NONE	
FAMILY EDUCATION		FAMILY OCCUPATION		FAMILY INCOME	
NONE		NONE		NONE	

DEPARTMENT OF HEALTH

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH

14038

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 Hr d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor d. STREET ADDRESS 3833 Bladensburg Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Paul Sr. Duvall		4. DATE OF DEATH Month Dec Day 18 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 11, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 1 Days 18 Hours 19 Min.	11. IF UNDER 24 HRS. Months 1 Days 18 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bar Tender	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John W Duvall		14. MOTHER'S MAIDEN NAME Lillian Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 213 16 244A	
17. INFORMANT Ann L Duvall		Address Colmar Manor Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes mellitus DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-13 , 19 59 to Dec. 18 , 19 59 that I last saw the deceased alive on Dec. 18 , 19 59 , and that death occurred at 1:30 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE George Hageage		ADDRESS (Street, city or town, state) 3717-38th Ave Cottage City, Md	
PHYSICIAN'S NAME (Type) Dr. Geo. Hageage, M.D.		DATE SIGNED 12-18-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12/22/59	22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	22d. LOCATION (City, town, or county) (State) Wheaton Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DEC 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

16638

Name of deceased: [illegible]

Sex: [illegible] Age: [illegible]

Place of birth: [illegible]

Date of birth: [illegible]

Place of death: [illegible]

Date of death: [illegible]

Time of death: [illegible]

Cause of death: [illegible]

Immediate cause: [illegible]

Underlying cause: [illegible]

Contributing cause: [illegible]

Occupation: [illegible]

Signature of physician: [illegible]

Signature of registrar: [illegible]

Signature of informant: [illegible]

Signature of medical examiner: [illegible]

Signature of coroner: [illegible]

Signature of health officer: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled with the information required by the law. The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled with the information required by the law. The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled with the information required by the law.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14039

CERTIFICATE OF DEATH

Reg. Dist. No.

14003

1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Lanham Hills		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. STREET ADDRESS 7726 Emerson Road		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First Middle Last (Dyer) Regina A Dyer		4. DATE OF DEATH Month Day Year Dec. 25 19 59		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 8, 1959		9. AGE (In years last birthday) 6 Weeks		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME James R. Dyer		14. MOTHER'S MAIDEN NAME Sandra Ripka	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT Father James R Dyer West Lanham Hills Md.		Address		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Murder 756.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hyper trophic pylorostenosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cottage City, Md.		20g. (County)		20h. (State)		21. I certify that I attended the deceased from Nov. 8, 1959 , to Dec. 25, 1959 , that I last saw the deceased alive on Dec. 24, 1959 , and that death occurred at 7:30 AM , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) 3717-38th Ave 12-59	
ACTUAL SIGNATURE George Hageage		PHYSICIAN'S NAME (Type) Dr. George Hageage, M.D.		23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR DATE DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank		25. LOCATION (City, town, or county) (State) Washington D. C.	

2077213XV4

CENTRAL CASE OF DEATH

10082

M

Police Officer

Police Officer

Police Officer

Police Officer

Police Officer

Police Officer

Police Officer

Police Officer

Police Officer

Police Officer

Police Officer

Police Officer

Police Officer

Police Officer

Police Officer

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[Faint, illegible handwriting]

14904

14040

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 Month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital			d. STREET ADDRESS 3005 Cheverly Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last James Frederick Dyson			4. DATE OF DEATH Month Day Year Dec. 1 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-86		9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postal Employee		10b. KIND OF BUSINESS OR INDUSTRY Md		11. BIRTHPLACE (State or foreign country) U S A.	
13. FATHER'S NAME William W Dyson			14. MOTHER'S MAIDEN NAME Katherine Moran		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		INFORMANT Address Vivian Huntley Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia & Renal Insufficiency DUE TO (c) Chronic Benign Prostatic Hypertrophy					INTERVAL BETWEEN ONSET AND DEATH 11/59 1955
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystectomy & Pancreatotomy for CA in 1949					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 10:30 Dec. 1 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 11/13 , 19 59 , to 12/1 , 19 59 , that I last saw the deceased alive on 11/30 , 19 59 , and that death occurred at 10:30 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE William A. Stecher		M.D. 6300 Riverdale Rd ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) WILLIAM A. STECHER		RIVERDALE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 4, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
				22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F GASCH Sons		ADDRESS HYATTSVILLE Md		24a. REC'D BY REGISTRAR DATE DEC 4 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Birth Date

Birth Time

Birth Place

Parents

Birth Certificate

Registration

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Birth Record

Birth Entry

Birth Certificate

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Birth Certificate

Birth Certificate

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Birth Certificate

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14005

14012

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSTVILLE c. LENGTH OF STAY IN 1b <i>Jan. 11/59</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PAINT BRANCH NURSING HOME				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. d. STREET ADDRESS 2701 17th. street, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SAMUEL R. EDMONDS			4. DATE OF DEATH Month 12 Day 18 Year 19 59				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1880		9. AGE (In years last birthday) 79 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PROPRIETOR CINDER		10b. KIND OF BUSINESS OR INDUSTRY BLOCK BUSINESS		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.			
13. FATHER'S NAME JOHN ROBERT EDMONDS			14. MOTHER'S MAIDEN NAME ANNIE BROWN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-03-3976		17. INFORMANT 3200 Cheverly Avenue HAZEL B. LA MAR Cheverly, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular renal disease</i> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John J. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) JOHN T. MALONEY, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12-19-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/21/1959	22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) COLMAR MANOR, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maloney's Funeral Home</i>		ADDRESS <i>Mt. Rainier Md.</i>		24a. REC'D BY REGISTRAR DATE DEC 22 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14017

CERTIFICATE OF DEATH

Reg. Dist. No. 14006

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY PR. GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT RAINIER				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 MT RAINIER			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle ERNEST Last EDWARDS				4. DATE OF DEATH Month DEC Day 8 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 22, 1881	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY STEEL MILL		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABRAHAM EDWARDS				14. MOTHER'S MAIDEN NAME POLLY MINTEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 271-03-7569		17. INFORMANT CHANCEY EDWARDS		Address LAUREL, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF COLON DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 1 MONTH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month 19 Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from NOV 1, 1959 to DEC 8, 1959 , that I last saw the deceased alive on DEC 8, 1959 , and that death occurred at 11:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel J. Sugar			ADDRESS (Street, city or town, state) 4300 KAYWOOD DRIVE MT RAINIER, Md.		DATE SIGNED Dec 8, 1959		
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR							
22a. BURIAL CREMATION, REMOVAL, ETC.	22b. DATE THEREOF 12-12-1959	22c. NAME OF CEMETERY OR CREMATORY Grand-View	22d. LOCATION (City, town, or county) (State) Strasburg, Ohio				
23. FUNERAL DIRECTOR'S SIGNATURE Robert X Amattiny		ADDRESS 131-11 Wash, DC	24a. REC'D BY REGISTRAR DEC 11 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14907

14102

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Park.</u>		c. LENGTH OF STAY IN 1b <u>3yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4615 Brookfield Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>R.</u> Last <u>EDWARDS</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucas</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 14, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Gilbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Anna Tomlinson</u>		Address <u>4615 Brookfield Dr</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular - renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Hypertensive heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>1 year</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old left hemiplegia - 15 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 2, 1956</u> , to <u>Dec - 26, 1959</u> that I last saw the deceased alive on <u>12-26-</u> , 19 <u>59</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>5731 23rd Parkway SE</u> <u>12-26-59</u>			
ACTUAL SIGNATURE <u>David S. Gordon</u> M.D.		PHYSICIAN'S NAME (Type) <u>DAVID S. GORDON, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-30-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co Inc</u>		24a. REC'D BY REGISTRAR <u>DEC 29 '59</u>	
ADDRESS <u>Washington, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

14003

CERTIFICATE OF DEATH

14008

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9001 - 48th Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Eshenour</u> Last <u>Dec</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 10, 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar Eshenour</u>		14. MOTHER'S MAIDEN NAME <u>Annie Hocker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>Lloyd Eshenour, College Park Md</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>962X</u> DUE TO <u>Cerebral atrophy & degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>permanent lrt hemiplegia</u> DUE TO <u>from accident (1892)</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Dropped by farm harrow</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>892</u> 19 p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/> <u>Club</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) <u>Rutherford</u> (County) <u>Pa.</u> (State) <u>Pa.</u>	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>49</u> , to <u>DEC</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>DEC 10</u> , 19 <u>59</u> , and that death occurred at <u>530 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Al Etienne</u>		ADDRESS (Street, city or town, state) <u>4713 - Burgess Rd College Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W. L. Etienne</u>		DATE SIGNED <u>12/10/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 14, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chambers - Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Harrisburg Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>4737 - Balt. Ave.</u>	
24a. REC'D BY REGISTRAR <u>DEC 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10002



14041 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Trinidad</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Reagon Garfield Ferguson</u>		4. DATE OF DEATH <u>Dec 17 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-25-81</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>US Govt. Public Works</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Ferguson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Beach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Clinton Ferguson</u>	
17. INFORMANT <u>Clinton Ferguson</u>		Address <u>Same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u>Cardiovascular renal disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John F. Maloney</u>		DATE SIGNED <u>12-17-59</u>	
EXAMINER'S NAME (Type) <u>JOHN F. MALONEY M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Col-2901 14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>DEC 21 '59</u>	
ADDRESS <u>Washington 9, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Reg. Dist. No.

VS A15 (4)
15M 9/5B

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14018

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i>		c. LENGTH OF STAY IN 1b <i>10 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4019-36 St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth Alice Fleming</i>		4. DATE OF DEATH <i>Dec. 10, 1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>21 Nov</i>
9. AGE (In years lost birthday) <i>74</i> yrs.		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife own home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>London England, U.S.</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>David Hockney</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Margaret C. Hazel</i>	
17. INFORMANT Address: <i>Margaret C. Hazel</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 153.8 IMMEDIATE CAUSE (a) <i>Cancer large intestine</i> DUE TO (b) <i>4 months</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertensive heart disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9 Dec 59</i> to <i>10 Dec 59</i> , that I last saw the deceased alive on <i>9 Dec 59</i> , and that death occurred at <i>8 a. m.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thomas E. Mattingly M.D.</i>		ADDRESS (Street, city or town, state) <i>2200 R. I. Ave N.E. 18, D.C.</i>	
PHYSICIAN'S NAME (Type) <i>Thomas E. Mattingly, M.D.</i>		DATE <i>10 Dec 59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/12/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kalley's Funeral Home Inc.</i>		24a. REC'D BY REGISTRAR <i>mt. Rainier Md.</i>	
24b. REGISTRAR'S SIGNATURE <i>Orlwin S. Hanna</i>		DATE <i>DEC 14 '59</i>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

14012

14043

1. PLACE OF DEATH a. COUNTY Brince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 9 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS 6838 Barton Rd.	
3. NAME OF DECEASED (Type or print) First Sophia Middle Brantz Last Fletcher				4. DATE OF DEATH Month Dec. Day 3 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 16, 1959	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min.		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Illinois	
13. FATHER'S NAME Ernest Brantz				14. MOTHER'S MAIDEN NAME Elizabeth Reit			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 357-22-5724			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia 332x DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Cerebral arteriosclerosis DUE TO (c) Cerebral arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple gastric ulcers.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 24 , 1959, to Dec. 3 , 1959, that I last saw the deceased alive on Dec. 3 , 1959, and that death occurred at 2:35 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) 4410 74th Ave., Hyattsville, Md.			
PHYSICIAN'S NAME (Type) [Signature]				DATE SIGNED DEC 7 '59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 12-5-1959			
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.				22d. LOCATION (City, town, or county) (State) Colmor Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J.Wm. Lee's Sons Co.				24a. REC'D BY REGISTRAR DEC 7 '59			
ADDRESS Wash. 2 D.C. 300-4th Street N.E.				24b. REGISTRAR'S SIGNATURE Arthur S. Hanes			

1. CERTIFICATE OF DEATH

1866

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

14044

CERTIFICATE OF DEATH

14013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt				c. LENGTH OF STAY IN 1b 8 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 38 F--Crescent Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle FANNIE H. Last FLORENCE				4. DATE OF DEATH Month December Day 29th Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 5th, 1886	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Taneytown, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Tobias Martin				14. MOTHER'S MAIDEN NAME Ida (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Paul R. Florence, 38 F--Crescent Rd., Greenbelt, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO (c) 5 yrs INTERVAL BETWEEN ONSET AND DEATH 1 hr							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> o. m. <input type="checkbox"/> p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/2 19 58 , to 12/29 19 59 , that I last saw the deceased alive on 12/14 19 59 , and that death occurred at 5:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3503 Perry Street, Mt. Rainier, Md. DATE SIGNED 12/30/1959							
ACTUAL SIGNATURE Norman D. Comeau M.D.							
PHYSICIAN'S NAME (Type) Norman D. Comeau							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/1960		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE JAN 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12044

PLACE OF BIRTH BALTIMORE, MARYLAND		SEX MALE	
DATE OF BIRTH JANUARY 1, 1900		AGE 25 YEARS	
PLACE OF DEATH BALTIMORE, MARYLAND		DATE OF DEATH JANUARY 1, 1925	
TIME OF DEATH 10:00 A.M.		CAUSE OF DEATH HEART DISEASE	
PLACE OF INTERMENT BALTIMORE, MARYLAND		DATE OF INTERMENT JANUARY 1, 1925	
NAME OF DECEASED JOHN J. BROWN		NAME OF NEXT OF KIN MARY J. BROWN	
ADDRESS OF DECEASED 1234 BALTIMORE ST., BALTIMORE, MD.		ADDRESS OF NEXT OF KIN 1234 BALTIMORE ST., BALTIMORE, MD.	
OCCUPATION OF DECEASED CLERK		OCCUPATION OF NEXT OF KIN HOUSEWIFE	
MARITAL STATUS SINGLE		MANNER OF DEATH NATURAL	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN MARY J. BROWN	
SIGNATURE OF PHYSICIAN DR. J. H. SMITH		SIGNATURE OF CORONER J. H. SMITH	
SIGNATURE OF REGISTRAR J. H. SMITH		SIGNATURE OF CLERK J. H. SMITH	

THIS CERTIFICATE IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, ON JANUARY 1, 1925.

CERTIFICATE OF DEATH

Reg. Dist. No.

14014

14006

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLD</u> b. COUNTY <u>PR. GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>French</u> Last <u>French</u>				4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4.1.1902</u>	
9. AGE (In years lost birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John. C. French</u>				14. MOTHER'S MAIDEN NAME <u>Jennie. E. Beck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Mildred. Wagner. 4618. Harvard. Rd. College</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>left breast</u> DUE TO (c) <u>3 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>59</u> , to <u>DEC. 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 25</u> , 19 <u>59</u> , and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Leonard Gold</u>				ADDRESS (Street, city or town, state) <u>8641 Colesville Road</u>			
PHYSICIAN'S NAME (Type) <u>Silver Spring, Md.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12.28.59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D C1</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>				ADDRESS <u>300. 4th. st N E.</u>		24a. REC'D BY REGISTRAR <u>DEC 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. L. S. Hall</u>			

for, Internal Home 300. 4th. 20 N. E.

Commission 1. 18. 22 1st's Crematory

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CERTIFICATE OF DEATH

Reg. Dist. No.

14015

14045

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 14 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Johanna Middle L. Last Funk		4. DATE OF DEATH Month Dec. Day 31 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1892
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min.	11. IF UNDER 24 HRS. Months 67 Days 67 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William E. Emmerich		14. MOTHER'S MAIDEN NAME Henrietta Demmo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Carl V. Funk 7802 Cross St. Lanham, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction, massive, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease + DUE TO (c) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/17 , 19 59 , to 12/31 , 19 59 , that I last saw the deceased alive on 12/31/59 , 19 59 , and that death occurred at 5:40 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Barry Rosenberg		ADDRESS (Street, city or town, state) 5102 Annapolis Road	
PHYSICIAN'S NAME (Type) Barry Rosenberg.		DATE SIGNED 12/31/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-5-1960	
22c. NAME OF CEMETERY OR CREMATORY London Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong ADDRESS 3704 North Ave		24a. REC'D BY REGISTRAR JAN 4 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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14046

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 137 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 817 58 th Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Edward Middle B Last Garrett				4. DATE OF DEATH Month Dec. Day 28 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 April 1901	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 5 Days 5		IF UNDER 24 HRS. Hours 5 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY U.S.Govt		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Emmett Garrett				14. MOTHER'S MAIDEN NAME Emma Bruce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW 2			
17. INFORMANT Robina S. Garrett				Address Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Encephalomalacia DUE TO (c) Cerebral arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 days 5 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept , 19 57 , to Dec 28th , 19 59 , that I last saw the deceased alive on 28 Dec. , 19 59 , and that death occurred at 3:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6117 Clearfield Drive Seat Pleasant, Md DATE SIGNED 28 Dec. 59							
ACTUAL SIGNATURE Peter Duus				M.D. 6117 Clearfield Drive Seat Pleasant, Md			
PHYSICIAN'S NAME (Type) Peter Duus., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-59		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl		22d. LOCATION (City, town, or county) (State) 2x Myer, Va	
23. FUNERAL DIRECTOR'S SIGNATURE B. G. Mattering				ADDRESS 131-114 St. E.		24a. REC'D BY REGISTRAR DATE DEC 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14002

EXHIBIT OF

Concluded at this session
Concluded at this session
Concluded at this session
Concluded at this session

12-31-21
12-31-21
12-31-21
12-31-21

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Page 4
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14047
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 11 Film G-53 12-29-59 et
CERTIFICATE OF DEATH

14017

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Gordon Last Gordon		4. DATE OF DEATH Month Dec. Day 14 Year 19 59	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Nov 1881
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Samuel		14. MOTHER'S MAIDEN NAME Harriet Shorter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Informant Address 5507 Sheriff Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 153.3 DUE TO Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Adeno carcinoma of the sigmoid colon DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19__ to Dec 14 , 19 59 , that I lost saw the deceased alive on Dec 14 , 19 59 , and that death occurred at 5:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Louis Mendel		ADDRESS (Street, city or town, state) 4506 COLLEGE AVE DATE SIGNED 12/15/59	
PHYSICIAN'S NAME (Type) C. LOUIS MENDEL		COLLEGE PARK MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-19-59		22b. DATE THEREOF Harmony	
22c. NAME OF CEMETERY OR CREMATORY Harmony		22d. LOCATION (City, town, or county) (State) Sherriff Rd Ex. Md	
23. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington ADDRESS 4925 Jones Ave NE		24a. REC'D BY REGISTRAR DEC 22 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

417000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14018

14048

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>325 Main Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Vincent</u> First <u>Greco</u> Middle <u>(GRECO)</u> Last		4. DATE OF DEATH <u>Dec. 12</u> 19 <u>59</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15 1885</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own barbershop</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nancy Greco</u>		14. MOTHER'S MAIDEN NAME <u>Rose Fava</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>325 Main St</u>	
17. INFORMANT <u>Mrs Theresa Greco</u>		Address <u>Lanham Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary thrombosis.</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Coronary thrombosis.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>12-11</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Idolo Pierandrei</u> M.D.			
PHYSICIAN'S NAME (Type) <u>IDOLO PIERANDREI</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cn</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr Will Sanderson</u>		24a. REC'D BY REGISTRAR <u>DEC 17 '59</u>	
ADDRESS <u>Lanham Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1900

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Age and Sex

Full Name of Deceased

Date of Death

Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Minister

Signature of Justice

Signature of Sheriff

Signature of Constable

Signature of Undertaker

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

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Signature of Interment

Signature of Burial

CERTIFICATE OF DEATH

Reg. Dist. No.

14019

14049

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 6 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS Rt. 2 Box 284		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Green		4. DATE OF DEATH Month Day Year Dec. 23 19 59			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-56	9. AGE (In years last birthday) 3 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None- child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Prince Geo. Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Alvin Green		14. MOTHER'S MAIDEN NAME Elsa M. Savoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT James Alvin Green		Address Clinton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 432x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac decompensation DUE TO cardiac tamponade (c) Purulent pericarditis					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 17, 19 59 to Dec. 23, 19 59 , that I last saw the deceased alive on Dec. 23, 19 59 , and that death occurred at 10:05 M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Bertha Van Gelderen		ADDRESS (Street, city or town, state) 3001 Riverly Ave, Annapolis, Md.			
PHYSICIAN'S NAME (Type) Bertha Van Gelderen		DATE SIGNED DEC 28 '59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-59		22c. NAME OF CEMETERY OR CREMATORY Holy Rosary St. John	
22d. LOCATION (City, town, or county) Clinton		22e. (State) Md.		22f. (Country)	
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle K. Collins		23a. REC'D BY REGISTRAR DEC 28 '59		23b. REGISTRAR'S SIGNATURE Arthur L. Kross	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1000

10

1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14103

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Goodwood Farm</u>			d. STREET ADDRESS <u>Rt 1 Box 63</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Carter</u> First <u>Frances</u> Middle <u>Hall</u> Last			4. DATE OF DEATH <u>Dec</u> Month <u>15</u> Year <u>1957</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1890</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Solemnar</u>		10b. KIN (On a separate sheet) <u>Wife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Nicholas Anorden Hall</u>			14. MOTHER'S MAIDEN NAME <u>Estelle Gullin</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>1508-40124-577-22-9839A</u>		
17. INFORMANT <u>Mr. Catherine E. Hall, same as #2</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u>Cardiovascular renal disease</u> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>James T. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>JAMES T. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Dec 15, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Funeral Home - Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. PLACE OF DEATH	
3. SEX		4. AGE	
5. RACE		6. OCCUPATION	
7. MARITAL STATUS		8. EDUCATION	
9. RELIGION		10. SOCIAL HISTORY	
11. PRESENT ILLNESS		12. HISTORY OF PRESENT ILLNESS	
13. PHYSICAL EXAMINATION		14. LABORATORY EXAMINATIONS	
15. PATHOLOGICAL FINDINGS		16. CAUSE OF DEATH	
17. MANNER OF DEATH		18. SIGNATURE OF EXAMINER	
19. DATE OF DEATH		20. TIME OF DEATH	
21. PLACE OF BURIAL		22. SIGNATURE OF REGISTRAR	
23. DATE OF REGISTRATION		24. TIME OF REGISTRATION	
25. OFFICE OF REGISTRAR		26. ADDRESS OF REGISTRAR	
27. TELEPHONE OF REGISTRAR		28. FAX OF REGISTRAR	
29. E-MAIL OF REGISTRAR		30. WEBSITE OF REGISTRAR	
31. SOCIAL MEDIA OF REGISTRAR		32. OTHER CONTACT INFORMATION	
33. NOTES		34. ADDITIONAL COMMENTS	
35. SIGNATURE OF WITNESS		36. DATE OF SIGNATURE	
37. ADDRESS OF WITNESS		38. TELEPHONE OF WITNESS	
39. E-MAIL OF WITNESS		40. OTHER CONTACT INFORMATION	
41. SIGNATURE OF CORONER		42. DATE OF SIGNATURE	
43. ADDRESS OF CORONER		44. TELEPHONE OF CORONER	
45. E-MAIL OF CORONER		46. OTHER CONTACT INFORMATION	
47. SIGNATURE OF JURY		48. DATE OF SIGNATURE	
49. ADDRESS OF JURY		45. TELEPHONE OF JURY	
50. E-MAIL OF JURY		51. OTHER CONTACT INFORMATION	
52. SIGNATURE OF JUDGE		53. DATE OF SIGNATURE	
54. ADDRESS OF JUDGE		55. TELEPHONE OF JUDGE	
56. E-MAIL OF JUDGE		57. OTHER CONTACT INFORMATION	
58. SIGNATURE OF PROSECUTOR		59. DATE OF SIGNATURE	
60. ADDRESS OF PROSECUTOR		61. TELEPHONE OF PROSECUTOR	
62. E-MAIL OF PROSECUTOR		63. OTHER CONTACT INFORMATION	
64. SIGNATURE OF DEFENSE ATTORNEY		65. DATE OF SIGNATURE	
66. ADDRESS OF DEFENSE ATTORNEY		67. TELEPHONE OF DEFENSE ATTORNEY	
68. E-MAIL OF DEFENSE ATTORNEY		69. OTHER CONTACT INFORMATION	
70. SIGNATURE OF JURY		71. DATE OF SIGNATURE	
72. ADDRESS OF JURY		73. TELEPHONE OF JURY	
74. E-MAIL OF JURY		75. OTHER CONTACT INFORMATION	
76. SIGNATURE OF JUDGE		77. DATE OF SIGNATURE	
78. ADDRESS OF JUDGE		79. TELEPHONE OF JUDGE	
80. E-MAIL OF JUDGE		81. OTHER CONTACT INFORMATION	
82. SIGNATURE OF PROSECUTOR		83. DATE OF SIGNATURE	
84. ADDRESS OF PROSECUTOR		85. TELEPHONE OF PROSECUTOR	
86. E-MAIL OF PROSECUTOR		87. OTHER CONTACT INFORMATION	
88. SIGNATURE OF DEFENSE ATTORNEY		89. DATE OF SIGNATURE	
90. ADDRESS OF DEFENSE ATTORNEY		91. TELEPHONE OF DEFENSE ATTORNEY	
92. E-MAIL OF DEFENSE ATTORNEY		93. OTHER CONTACT INFORMATION	
94. SIGNATURE OF JURY		95. DATE OF SIGNATURE	
96. ADDRESS OF JURY		97. TELEPHONE OF JURY	
98. E-MAIL OF JURY		99. OTHER CONTACT INFORMATION	
100. SIGNATURE OF JUDGE		101. DATE OF SIGNATURE	
102. ADDRESS OF JUDGE		103. TELEPHONE OF JUDGE	
104. E-MAIL OF JUDGE		105. OTHER CONTACT INFORMATION	
106. SIGNATURE OF PROSECUTOR		107. DATE OF SIGNATURE	
108. ADDRESS OF PROSECUTOR		109. TELEPHONE OF PROSECUTOR	
110. E-MAIL OF PROSECUTOR		111. OTHER CONTACT INFORMATION	
112. SIGNATURE OF DEFENSE ATTORNEY		113. DATE OF SIGNATURE	
114. ADDRESS OF DEFENSE ATTORNEY		115. TELEPHONE OF DEFENSE ATTORNEY	
116. E-MAIL OF DEFENSE ATTORNEY		117. OTHER CONTACT INFORMATION	
118. SIGNATURE OF JURY		119. DATE OF SIGNATURE	
120. ADDRESS OF JURY		121. TELEPHONE OF JURY	
122. E-MAIL OF JURY		123. OTHER CONTACT INFORMATION	
124. SIGNATURE OF JUDGE		125. DATE OF SIGNATURE	
126. ADDRESS OF JUDGE		127. TELEPHONE OF JUDGE	
128. E-MAIL OF JUDGE		129. OTHER CONTACT INFORMATION	
130. SIGNATURE OF PROSECUTOR		131. DATE OF SIGNATURE	
132. ADDRESS OF PROSECUTOR		133. TELEPHONE OF PROSECUTOR	
134. E-MAIL OF PROSECUTOR		135. OTHER CONTACT INFORMATION	
136. SIGNATURE OF DEFENSE ATTORNEY		137. DATE OF SIGNATURE	
138. ADDRESS OF DEFENSE ATTORNEY		139. TELEPHONE OF DEFENSE ATTORNEY	
140. E-MAIL OF DEFENSE ATTORNEY		141. OTHER CONTACT INFORMATION	
142. SIGNATURE OF JURY		143. DATE OF SIGNATURE	
144. ADDRESS OF JURY		145. TELEPHONE OF JURY	
146. E-MAIL OF JURY		147. OTHER CONTACT INFORMATION	
148. SIGNATURE OF JUDGE		149. DATE OF SIGNATURE	
150. ADDRESS OF JUDGE		151. TELEPHONE OF JUDGE	
152. E-MAIL OF JUDGE		153. OTHER CONTACT INFORMATION	
154. SIGNATURE OF PROSECUTOR		155. DATE OF SIGNATURE	
156. ADDRESS OF PROSECUTOR		157. TELEPHONE OF PROSECUTOR	
158. E-MAIL OF PROSECUTOR		159. OTHER CONTACT INFORMATION	
160. SIGNATURE OF DEFENSE ATTORNEY		161. DATE OF SIGNATURE	
162. ADDRESS OF DEFENSE ATTORNEY		163. TELEPHONE OF DEFENSE ATTORNEY	
164. E-MAIL OF DEFENSE ATTORNEY		165. OTHER CONTACT INFORMATION	
166. SIGNATURE OF JURY		167. DATE OF SIGNATURE	
168. ADDRESS OF JURY		169. TELEPHONE OF JURY	
170. E-MAIL OF JURY		171. OTHER CONTACT INFORMATION	
172. SIGNATURE OF JUDGE		173. DATE OF SIGNATURE	
174. ADDRESS OF JUDGE		175. TELEPHONE OF JUDGE	
176. E-MAIL OF JUDGE		177. OTHER CONTACT INFORMATION	
178. SIGNATURE OF PROSECUTOR		179. DATE OF SIGNATURE	
180. ADDRESS OF PROSECUTOR		181. TELEPHONE OF PROSECUTOR	
182. E-MAIL OF PROSECUTOR		183. OTHER CONTACT INFORMATION	
184. SIGNATURE OF DEFENSE ATTORNEY		185. DATE OF SIGNATURE	
186. ADDRESS OF DEFENSE ATTORNEY		187. TELEPHONE OF DEFENSE ATTORNEY	
188. E-MAIL OF DEFENSE ATTORNEY		189. OTHER CONTACT INFORMATION	
190. SIGNATURE OF JURY		191. DATE OF SIGNATURE	
192. ADDRESS OF JURY		193. TELEPHONE OF JURY	
194. E-MAIL OF JURY		195. OTHER CONTACT INFORMATION	
196. SIGNATURE OF JUDGE		197. DATE OF SIGNATURE	
198. ADDRESS OF JUDGE		199. TELEPHONE OF JUDGE	
200. E-MAIL OF JUDGE		201. OTHER CONTACT INFORMATION	
202. SIGNATURE OF PROSECUTOR		203. DATE OF SIGNATURE	
204. ADDRESS OF PROSECUTOR		205. TELEPHONE OF PROSECUTOR	
206. E-MAIL OF PROSECUTOR		207. OTHER CONTACT INFORMATION	
208. SIGNATURE OF DEFENSE ATTORNEY		209. DATE OF SIGNATURE	
210. ADDRESS OF DEFENSE ATTORNEY		211. TELEPHONE OF DEFENSE ATTORNEY	
212. E-MAIL OF DEFENSE ATTORNEY		213. OTHER CONTACT INFORMATION	
214. SIGNATURE OF JURY		215. DATE OF SIGNATURE	
216. ADDRESS OF JURY		217. TELEPHONE OF JURY	
218. E-MAIL OF JURY		219. OTHER CONTACT INFORMATION	
220. SIGNATURE OF JUDGE		221. DATE OF SIGNATURE	
222. ADDRESS OF JUDGE		223. TELEPHONE OF JUDGE	
224. E-MAIL OF JUDGE		225. OTHER CONTACT INFORMATION	
226. SIGNATURE OF PROSECUTOR		227. DATE OF SIGNATURE	
228. ADDRESS OF PROSECUTOR		229. TELEPHONE OF PROSECUTOR	
230. E-MAIL OF PROSECUTOR		231. OTHER CONTACT INFORMATION	
232. SIGNATURE OF DEFENSE ATTORNEY		233. DATE OF SIGNATURE	
234. ADDRESS OF DEFENSE ATTORNEY		235. TELEPHONE OF DEFENSE ATTORNEY	
236. E-MAIL OF DEFENSE ATTORNEY		237. OTHER CONTACT INFORMATION	
238. SIGNATURE OF JURY		239. DATE OF SIGNATURE	
240. ADDRESS OF JURY		241. TELEPHONE OF JURY	
242. E-MAIL OF JURY		243. OTHER CONTACT INFORMATION	
244. SIGNATURE OF JUDGE		245. DATE OF SIGNATURE	
246. ADDRESS OF JUDGE		247. TELEPHONE OF JUDGE	
248. E-MAIL OF JUDGE		249. OTHER CONTACT INFORMATION	
250. SIGNATURE OF PROSECUTOR		251. DATE OF SIGNATURE	
252. ADDRESS OF PROSECUTOR		253. TELEPHONE OF PROSECUTOR	
254. E-MAIL OF PROSECUTOR		255. OTHER CONTACT INFORMATION	
256. SIGNATURE OF DEFENSE ATTORNEY		257. DATE OF SIGNATURE	
258. ADDRESS OF DEFENSE ATTORNEY		259. TELEPHONE OF DEFENSE ATTORNEY	
260. E-MAIL OF DEFENSE ATTORNEY		261. OTHER CONTACT INFORMATION	
262. SIGNATURE OF JURY		263. DATE OF SIGNATURE	
264. ADDRESS OF JURY		265. TELEPHONE OF JURY	
266. E-MAIL OF JURY		267. OTHER CONTACT INFORMATION	
268. SIGNATURE OF JUDGE		269. DATE OF SIGNATURE	
270. ADDRESS OF JUDGE		271. TELEPHONE OF JUDGE	
272. E-MAIL OF JUDGE		273. OTHER CONTACT INFORMATION	
274. SIGNATURE OF PROSECUTOR		275. DATE OF SIGNATURE	
276. ADDRESS OF PROSECUTOR		277. TELEPHONE OF PROSECUTOR	
278. E-MAIL OF PROSECUTOR		279. OTHER CONTACT INFORMATION	
280. SIGNATURE OF DEFENSE ATTORNEY		281. DATE OF SIGNATURE	
282. ADDRESS OF DEFENSE ATTORNEY		283. TELEPHONE OF DEFENSE ATTORNEY	
284. E-MAIL OF DEFENSE ATTORNEY		285. OTHER CONTACT INFORMATION	
286. SIGNATURE OF JURY		287. DATE OF SIGNATURE	
288. ADDRESS OF JURY		289. TELEPHONE OF JURY	
290. E-MAIL OF JURY		291. OTHER CONTACT INFORMATION	
292. SIGNATURE OF JUDGE		293. DATE OF SIGNATURE	
294. ADDRESS OF JUDGE		295. TELEPHONE OF JUDGE	
296. E-MAIL OF JUDGE		297. OTHER CONTACT INFORMATION	
298. SIGNATURE OF PROSECUTOR		299. DATE OF SIGNATURE	
300. ADDRESS OF PROSECUTOR		301. TELEPHONE OF PROSECUTOR	
302. E-MAIL OF PROSECUTOR		303. OTHER CONTACT INFORMATION	
304. SIGNATURE OF DEFENSE ATTORNEY		305. DATE OF SIGNATURE	
306. ADDRESS OF DEFENSE ATTORNEY		307. TELEPHONE OF DEFENSE ATTORNEY	
308. E-MAIL OF DEFENSE ATTORNEY		309. OTHER CONTACT INFORMATION	
310. SIGNATURE OF JURY		311. DATE OF SIGNATURE	
312. ADDRESS OF JURY		313. TELEPHONE OF JURY	
314. E-MAIL OF JURY		315. OTHER CONTACT INFORMATION	
316. SIGNATURE OF JUDGE		317. DATE OF SIGNATURE	
318. ADDRESS OF JUDGE		319. TELEPHONE OF JUDGE	
320. E-MAIL OF JUDGE		321. OTHER CONTACT INFORMATION	
322. SIGNATURE OF PROSECUTOR		323. DATE OF SIGNATURE	
324. ADDRESS OF PROSECUTOR		325. TELEPHONE OF PROSECUTOR	
326. E-MAIL OF PROSECUTOR		327. OTHER CONTACT INFORMATION	
328. SIGNATURE OF DEFENSE ATTORNEY		329. DATE OF SIGNATURE	
330. ADDRESS OF DEFENSE ATTORNEY		331. TELEPHONE OF DEFENSE ATTORNEY	
332. E-MAIL OF DEFENSE ATTORNEY		333. OTHER CONTACT INFORMATION	
334. SIGNATURE OF JURY		335. DATE OF SIGNATURE	
336. ADDRESS OF JURY		337. TELEPHONE OF JURY	
338. E-MAIL OF JURY		339. OTHER CONTACT INFORMATION	
340. SIGNATURE OF JUDGE		341. DATE OF SIGNATURE	
342. ADDRESS OF JUDGE		343. TELEPHONE OF JUDGE	
344. E-MAIL OF JUDGE		345. OTHER CONTACT INFORMATION	
346. SIGNATURE OF PROSECUTOR		347. DATE OF SIGNATURE	
348. ADDRESS OF PROSECUTOR		349. TELEPHONE OF PROSECUTOR	
350. E-MAIL OF PROSECUTOR		351. OTHER CONTACT INFORMATION	
352. SIGNATURE OF DEFENSE ATTORNEY		353. DATE OF SIGNATURE	
354. ADDRESS OF DEFENSE ATTORNEY		355. TELEPHONE OF DEFENSE ATTORNEY	
356. E-MAIL OF DEFENSE ATTORNEY		357. OTHER CONTACT INFORMATION	
358. SIGNATURE OF JURY		359. DATE OF SIGNATURE	
360. ADDRESS OF JURY		361. TELEPHONE OF JURY	
362. E-MAIL OF JURY		363. OTHER CONTACT INFORMATION	
364. SIGNATURE OF JUDGE		365. DATE OF SIGNATURE	
366. ADDRESS OF JUDGE		367. TELEPHONE OF JUDGE	
368. E-MAIL OF JUDGE		369. OTHER CONTACT INFORMATION	
370. SIGNATURE OF PROSECUTOR		371. DATE OF SIGNATURE	
372. ADDRESS OF PROSECUTOR		373. TELEPHONE OF PROSECUTOR	
374. E-MAIL OF PROSECUTOR		375. OTHER CONTACT INFORMATION	
376. SIGNATURE OF DEFENSE ATTORNEY		377. DATE OF SIGNATURE	
378. ADDRESS OF DEFENSE ATTORNEY		379. TELEPHONE OF DEFENSE ATTORNEY	
380. E-MAIL OF DEFENSE ATTORNEY		381. OTHER CONTACT INFORMATION	
382. SIGNATURE OF JURY		383. DATE OF SIGNATURE	
384. ADDRESS OF JURY		385. TELEPHONE OF JURY	
386. E-MAIL OF JURY		387. OTHER CONTACT INFORMATION	
388. SIGNATURE OF JUDGE		389. DATE OF SIGNATURE	
390. ADDRESS OF JUDGE		391. TELEPHONE OF JUDGE	
392. E-MAIL OF JUDGE		393. OTHER CONTACT INFORMATION	
394. SIGNATURE OF PROSECUTOR		395. DATE OF SIGNATURE	
396. ADDRESS OF PROSECUTOR		397. TELEPHONE OF PROSECUTOR	
398. E-MAIL OF PROSECUTOR		399. OTHER CONTACT INFORMATION	
400. SIGNATURE OF DEFENSE ATTORNEY		401. DATE OF SIGNATURE	
402. ADDRESS OF DEFENSE ATTORNEY		403. TELEPHONE OF DEFENSE ATTORNEY	
404. E-MAIL OF DEFENSE ATTORNEY		405. OTHER CONTACT INFORMATION	
406. SIGNATURE OF JURY		407. DATE OF SIGNATURE	
408. ADDRESS OF JURY		409. TELEPHONE OF JURY	
410. E-MAIL OF JURY		411. OTHER CONTACT INFORMATION	
412. SIGNATURE OF JUDGE		413. DATE OF SIGNATURE	
414. ADDRESS OF JUDGE		415. TELEPHONE OF JUDGE	
416. E-MAIL OF JUDGE		417. OTHER CONTACT INFORMATION	
418. SIGNATURE OF PROSECUTOR		419. DATE OF SIGNATURE	
420. ADDRESS OF PROSECUTOR		421. TELEPHONE OF PROSECUTOR	
422. E-MAIL OF PROSECUTOR		423. OTHER CONTACT INFORMATION	
424. SIGNATURE OF DEFENSE ATTORNEY		425. DATE OF SIGNATURE	
426. ADDRESS OF DEFENSE ATTORNEY		427. TELEPHONE OF DEFENSE ATTORNEY	
428. E-MAIL OF DEFENSE ATTORNEY		429. OTHER CONTACT INFORMATION	
430. SIGNATURE OF JURY		431. DATE OF SIGNATURE	
432. ADDRESS OF JURY		433. TELEPHONE OF JURY	
434. E-MAIL OF JURY		435. OTHER CONTACT INFORMATION	
436. SIGNATURE OF JUDGE		437. DATE OF SIGNATURE	
438. ADDRESS OF JUDGE		439. TELEPHONE OF JUDGE	
440. E-MAIL OF JUDGE		441. OTHER CONTACT INFORMATION	
442. SIGNATURE OF PROSECUTOR		443. DATE OF SIGNATURE	
444. ADDRESS OF PROSECUTOR		445. TELEPHONE OF PROSECUTOR	
446. E-MAIL OF PROSECUTOR		447. OTHER CONTACT INFORMATION	
448. SIGNATURE OF DEFENSE ATTORNEY		449. DATE OF SIGNATURE	
450. ADDRESS OF DEFENSE ATTORNEY		451. TELEPHONE OF DEFENSE ATTORNEY	
452. E-MAIL OF DEFENSE ATTORNEY		453. OTHER CONTACT INFORMATION	
454. SIGNATURE OF JURY		455. DATE OF SIGNATURE	
456. ADDRESS OF JURY		457. TELEPHONE OF JURY	
458. E-MAIL OF JURY		459. OTHER CONTACT INFORMATION	
460. SIGNATURE OF JUDGE		461. DATE OF SIGNATURE	
462. ADDRESS OF JUDGE		463. TELEPHONE OF JUDGE	
464. E-MAIL OF JUDGE		465. OTHER CONTACT INFORMATION	
466. SIGNATURE OF PROSECUTOR		467. DATE OF SIGNATURE	
468. ADDRESS OF PROSECUTOR		469. TELEPHONE OF PROSECUTOR	
470. E-MAIL OF PROSECUTOR		471. OTHER CONTACT INFORMATION	
472. SIGNATURE OF DEFENSE ATTORNEY		473. DATE OF SIGNATURE	
474. ADDRESS OF DEFENSE ATTORNEY		475. TELEPHONE OF DEFENSE ATTORNEY	
476. E-MAIL OF DEFENSE ATTORNEY		477. OTHER CONTACT INFORMATION	
478. SIGNATURE OF JURY		479. DATE OF SIGNATURE	
480. ADDRESS OF JURY		481. TELEPHONE OF JURY	
482. E-MAIL OF JURY		483. OTHER CONTACT INFORMATION	
484. SIGNATURE OF JUDGE		485. DATE OF SIGNATURE	
486. ADDRESS OF JUDGE		487. TELEPHONE OF JUDGE	
488. E-MAIL OF JUDGE		489. OTHER CONTACT INFORMATION	
490. SIGNATURE OF PROSECUTOR		491. DATE OF SIGNATURE	
492. ADDRESS OF PROSECUTOR		493. TELEPHONE OF PROSECUTOR	
494. E-MAIL OF PROSECUTOR		495. OTHER CONTACT INFORMATION	
496. SIGNATURE OF DEFENSE ATTORNEY		497. DATE OF SIGNATURE	
498. ADDRESS OF DEFENSE ATTORNEY		499. TELEPHONE OF DEFENSE ATTORNEY	
500. E-MAIL OF DEFENSE ATTORNEY		501. OTHER CONTACT INFORMATION	
502. SIGNATURE OF JURY		503. DATE OF SIGNATURE	
504. ADDRESS OF JURY		505. TELEPHONE OF JURY	
506. E-MAIL OF JURY		507. OTHER CONTACT INFORMATION	
508. SIGNATURE OF JUDGE		509. DATE OF SIGNATURE	
510. ADDRESS OF JUDGE		511. TELEPHONE OF JUDGE	
512. E-MAIL OF JUDGE		513. OTHER CONTACT INFORMATION	
514. SIGNATURE OF PROSECUTOR		515. DATE OF SIGNATURE	
516. ADDRESS OF PROSECUTOR		517. TELEPHONE OF PROSECUTOR	
518. E-MAIL OF PROSECUTOR		519. OTHER CONTACT INFORMATION	
520. SIGNATURE OF DEFENSE ATTORNEY		521. DATE OF SIGNATURE	
522. ADDRESS OF DEFENSE ATTORNEY		523. TELEPHONE OF DEFENSE ATTORNEY	
524. E-MAIL OF DEFENSE ATTORNEY		525. OTHER CONTACT INFORMATION	
526. SIGNATURE OF JURY		527. DATE OF SIGNATURE	
528. ADDRESS OF JURY		529. TELEPHONE OF JURY	
530. E-MAIL OF JURY		531. OTHER CONTACT INFORMATION	
532. SIGNATURE OF JUDGE		533. DATE OF SIGNATURE	
534. ADDRESS OF JUDGE		535. TELEPHONE OF JUDGE	
536. E-MAIL OF JUDGE		537. OTHER CONTACT INFORMATION	
538. SIGNATURE OF PROSECUTOR		539. DATE OF SIGNATURE	
540. ADDRESS OF PROSECUTOR		541. TELEPHONE OF PROSECUTOR	
542. E-MAIL OF PROSECUTOR		543. OTHER CONTACT INFORMATION	
544. SIGNATURE OF DEFENSE ATTORNEY		545. DATE OF SIGNATURE	
546. ADDRESS OF DEFENSE ATTORNEY		547. TELEPHONE OF DEFENSE ATTORNEY	
548. E-MAIL OF DEFENSE ATTORNEY		549. OTHER CONTACT INFORMATION	
550. SIGNATURE OF JURY		551. DATE OF SIGNATURE	
552. ADDRESS OF JURY		553. TELEPHONE OF JURY	
554. E-MAIL OF JURY		555. OTHER CONTACT INFORMATION	
556. SIGNATURE OF JUDGE		557. DATE OF SIGNATURE	
558. ADDRESS OF JUDGE		559. TELEPHONE OF JUDGE	
560. E-MAIL OF JUDGE		561. OTHER CONTACT INFORMATION	
562. SIGNATURE OF PROSECUTOR		563. DATE OF SIGNATURE	
564. ADDRESS OF PROSECUTOR		565. TELEPHONE OF PROSECUTOR	
566. E-MAIL OF PROSECUTOR		567. OTHER CONTACT INFORMATION	
568. SIGNATURE OF DEFENSE ATTORNEY		569. DATE OF SIGNATURE	
570. ADDRESS OF DEFENSE ATTORNEY		571. TELEPHONE OF DEFENSE ATTORNEY	
572. E-MAIL OF DEFENSE ATTORNEY		573. OTHER CONTACT INFORMATION	
574. SIGNATURE OF JURY		575. DATE OF SIGNATURE	
576. ADDRESS OF JURY		577. TELEPHONE OF JURY	
578. E-MAIL OF JURY		579. OTHER CONTACT INFORMATION	
580. SIGNATURE OF JUDGE		581. DATE OF SIGNATURE	
582. ADDRESS OF JUDGE		583. TELEPHONE OF JUDGE	
584. E-MAIL OF JUDGE		585. OTHER CONTACT INFORMATION	
586. SIGNATURE OF PROSECUTOR		587. DATE OF SIGNATURE	
588. ADDRESS OF PROSECUTOR		589. TELEPHONE OF PROSECUTOR	
590. E-MAIL OF PROSECUTOR		591. OTHER CONTACT INFORMATION	
592. SIGNATURE OF DEFENSE ATTORNEY		593. DATE OF SIGNATURE	
594. ADDRESS OF DEFENSE ATTORNEY		595. TELEPHONE OF DEFENSE ATTORNEY	
596. E-MAIL OF DEFENSE ATTORNEY		597. OTHER CONTACT INFORMATION	
598. SIGNATURE OF JURY		599. DATE OF SIGNATURE	
600. ADDRESS OF JURY		601. TELEPHONE OF JURY	
602. E-MAIL OF JURY		603. OTHER CONTACT INFORMATION	
604. SIGNATURE OF JUDGE		605. DATE OF SIGNATURE	
606. ADDRESS OF JUDGE		607. TELEPHONE OF JUDGE	
608. E-MAIL OF JUDGE		609. OTHER CONTACT INFORMATION	
610. SIGNATURE OF PROSECUTOR		611. DATE OF SIGNATURE	
612. ADDRESS OF PROSECUTOR		613. TELEPHONE OF PROSECUTOR	
614. E-MAIL OF PROSECUTOR		615. OTHER CONTACT INFORMATION	
616. SIGNATURE OF DEFENSE ATTORNEY		617. DATE OF SIGNATURE	
618. ADDRESS OF DEFENSE ATTORNEY		619. TELEPHONE OF DEFENSE ATTORNEY	
620. E-MAIL OF DEFENSE ATTORNEY		621. OTHER CONTACT INFORMATION	
622. SIGNATURE OF JURY		623. DATE OF SIGNATURE	
624. ADDRESS OF JURY		625. TELEPHONE OF JURY	
626. E-MAIL OF JURY		627. OTHER CONTACT INFORMATION	
628. SIGNATURE OF JUDGE		629. DATE OF SIGNATURE	
630. ADDRESS OF JUDGE		631. TELEPHONE OF JUDGE	
632. E-MAIL OF JUDGE		633. OTHER CONTACT INFORMATION	
634. SIGNATURE OF PROSECUTOR		635. DATE OF SIGNATURE	
636. ADDRESS OF PROSECUTOR		637. TELEPHONE OF PROSECUTOR	
638. E-MAIL OF PROSECUTOR		639. OTHER CONTACT INFORMATION	
640. SIGNATURE OF DEFENSE ATTORNEY		641. DATE OF SIGNATURE	
642. ADDRESS OF DEFENSE ATTORNEY		643. TELEPHONE OF DEFENSE ATTORNEY	
644. E-MAIL OF DEFENSE ATTORNEY		645. OTHER CONTACT INFORMATION	
646. SIGNATURE OF JURY		647.	

14050
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle William Last Hall		4. DATE OF DEATH Month DEC Day 1 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 3, 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83	11. IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min. 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Maintenance	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Hall		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mildred H Campbell		Address Los Angeles California.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Coronary Thrombosis with myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 29, 1959 , to DEC 1, 1959 , that I lost saw the deceased alive on Nov 30, 1959 , and that death occurred at 23 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. L. Etienne		DATE SIGNED 4713 - BERWYN Rd 12-1-59	
PHYSICIAN'S NAME (Type) W. L. ETIENNE		College PK, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/3/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DEC 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

VS A15 (4)
15M 9/58

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1930

11

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through from the reverse side.



1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14051

CERTIFICATE OF DEATH

Reg. Dist. No.

14023

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b X Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 6311 60th Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mark Middle Edward Jr. Last Hansford		4. DATE OF DEATH Month Dec. Day 17 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1959
9. AGE (In years last birthday) 7		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA S.A.	
13. FATHER'S NAME Mark Edward Hansford Sr.		14. MOTHER'S MAIDEN NAME Carole Jane Wombacker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital records	
17. ADDRESS Cheverly Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 763.0 Interstitial Pneumonitis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 _____			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-10 , 19 59 , to 12-17 , 19 59 , that I last saw the deceased alive on 12-17 , 19 59 , and that death occurred at 5:50 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3717 38th Ave. Cottage City, Md. DATE SIGNED 12-17-59			
ACTUAL SIGNATURE George f. Hageage M.D. 3717 38th Ave. Cottage City, Md.			
PHYSICIAN'S NAME (Type) Dr. Geo. Hageage, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Ceme.		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR DEC 23 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Hume	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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14104

CERTIFICATE OF DEATH

14024

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie Md		c. LENGTH OF STAY IN 1b 21 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1518 Chesnut avenue		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Agusta Elizabeth Harding		4. DATE OF DEATH Month Dec Day 13 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Treasurer Dept		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Reum		14. MOTHER'S MAIDEN NAME Annie Lyon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Richard Reum		Address Bowie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis with invasive metastasis to right lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of scalp DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 2 year 18 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/12/59 , to 12/13/59 , that I last saw the deceased alive on 12/12/59 , and that death occurred at 10:55 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. James Kurtz		DATE SIGNED 12/13/59	
PHYSICIAN'S NAME (Type) H. James Kurtz		ADDRESS (Street, city or town, state) R F D Bowie, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 16, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DEC 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kiana	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of birth: <i>Jan 15, 1900</i></p>	
<p>5. Place of birth: <i>New York City</i></p>		<p>6. Date of death: <i>Dec 10, 1945</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Place of death: <i>Home</i></p>	
<p>9. Signature of physician: <i>Dr. J. Smith</i></p>		<p>10. Signature of registrar: <i>John Doe</i></p>	
<p>11. Date of registration: <i>Dec 15, 1945</i></p>		<p>12. Office of registration: <i>New York City</i></p>	

RECEIVED
U.S. DEPT. OF HEALTH
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C.

14105

CERTIFICATE OF DEATH

14025

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE NONE Anne Arundel b. COUNTY NONE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				c. LENGTH OF STAY IN 1b 25 HRS 24 MIN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month DECEMBER Day 29 Year 19 59				5. SEX FEMALE 6. COLOR OR RACE CAU 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 28 DECEMBER 1959 9. AGE (In years lost birthday) yrs. 1 IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ROBERT L HAYMAN				14. MOTHER'S MAIDEN NAME HELEN J YORKLAND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT HOSPITAL RECORDS				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress of Newborn 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 762.5 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Premature birth							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 28 Dec , 19 59 , to 29 Dec , 19 59 , that I last saw the deceased alive on 0410 29 Dec , 19 59 , and that death occurred at 0410 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John A Moore M.D. USAF HOSPITAL ANDREWS, ANDREWS AFB WASH 25 DC							
PHYSICIAN'S NAME (Type) JOHN A MOORE, CAPT, USAF, MC USAF HOSPITAL ANDREWS, ANDREWS AFB WASH 25 DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-31-59							
22b. DATE THEREOF							
22c. NAME OF CEMETERY OR CREMATORY							
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE Hospital ADDRESS							
24a. REC'D BY REGISTRAR DATE JAN 4 '60							
24b. REGISTRAR'S SIGNATURE Arthur J. Thomas							

2050242XU2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1105

1. NAME OF DECEASED PRINCE DEWITT		2. SEX MALE		3. AGE 25	
4. PLACE OF BIRTH BALTIMORE, MARYLAND		5. DATE OF BIRTH JAN 20 1905		6. DATE OF DEATH JAN 20 1905	
7. PLACE OF DEATH BALTIMORE, MARYLAND		8. CAUSE OF DEATH DIPHTHERIA		9. MEDICAL HISTORY None	
10. NAME OF PHYSICIAN DR. J. H. HARRIS		11. NAME OF HOSPITAL BALTIMORE HOSPITAL		12. NAME OF NURSE MRS. J. H. HARRIS	
13. NAME OF FUNERAL HOME J. H. HARRIS		14. NAME OF BURIAL PLACE GREENWICH CEMETERY		15. NAME OF MINISTER J. H. HARRIS	
16. NAME OF WITNESS J. H. HARRIS		17. NAME OF WITNESS J. H. HARRIS		18. NAME OF WITNESS J. H. HARRIS	
19. NAME OF WITNESS J. H. HARRIS		20. NAME OF WITNESS J. H. HARRIS		21. NAME OF WITNESS J. H. HARRIS	
22. NAME OF WITNESS J. H. HARRIS		23. NAME OF WITNESS J. H. HARRIS		24. NAME OF WITNESS J. H. HARRIS	
25. NAME OF WITNESS J. H. HARRIS		26. NAME OF WITNESS J. H. HARRIS		27. NAME OF WITNESS J. H. HARRIS	
28. NAME OF WITNESS J. H. HARRIS		29. NAME OF WITNESS J. H. HARRIS		30. NAME OF WITNESS J. H. HARRIS	
31. NAME OF WITNESS J. H. HARRIS		32. NAME OF WITNESS J. H. HARRIS		33. NAME OF WITNESS J. H. HARRIS	
34. NAME OF WITNESS J. H. HARRIS		35. NAME OF WITNESS J. H. HARRIS		36. NAME OF WITNESS J. H. HARRIS	
37. NAME OF WITNESS J. H. HARRIS		38. NAME OF WITNESS J. H. HARRIS		39. NAME OF WITNESS J. H. HARRIS	
40. NAME OF WITNESS J. H. HARRIS		41. NAME OF WITNESS J. H. HARRIS		42. NAME OF WITNESS J. H. HARRIS	
43. NAME OF WITNESS J. H. HARRIS		44. NAME OF WITNESS J. H. HARRIS		45. NAME OF WITNESS J. H. HARRIS	
46. NAME OF WITNESS J. H. HARRIS		47. NAME OF WITNESS J. H. HARRIS		48. NAME OF WITNESS J. H. HARRIS	
49. NAME OF WITNESS J. H. HARRIS		50. NAME OF WITNESS J. H. HARRIS		51. NAME OF WITNESS J. H. HARRIS	
52. NAME OF WITNESS J. H. HARRIS		53. NAME OF WITNESS J. H. HARRIS		54. NAME OF WITNESS J. H. HARRIS	
55. NAME OF WITNESS J. H. HARRIS		56. NAME OF WITNESS J. H. HARRIS		57. NAME OF WITNESS J. H. HARRIS	
58. NAME OF WITNESS J. H. HARRIS		59. NAME OF WITNESS J. H. HARRIS		60. NAME OF WITNESS J. H. HARRIS	
61. NAME OF WITNESS J. H. HARRIS		62. NAME OF WITNESS J. H. HARRIS		63. NAME OF WITNESS J. H. HARRIS	
64. NAME OF WITNESS J. H. HARRIS		65. NAME OF WITNESS J. H. HARRIS		66. NAME OF WITNESS J. H. HARRIS	
67. NAME OF WITNESS J. H. HARRIS		68. NAME OF WITNESS J. H. HARRIS		69. NAME OF WITNESS J. H. HARRIS	
70. NAME OF WITNESS J. H. HARRIS		71. NAME OF WITNESS J. H. HARRIS		72. NAME OF WITNESS J. H. HARRIS	
73. NAME OF WITNESS J. H. HARRIS		74. NAME OF WITNESS J. H. HARRIS		75. NAME OF WITNESS J. H. HARRIS	
76. NAME OF WITNESS J. H. HARRIS		77. NAME OF WITNESS J. H. HARRIS		78. NAME OF WITNESS J. H. HARRIS	
79. NAME OF WITNESS J. H. HARRIS		80. NAME OF WITNESS J. H. HARRIS		81. NAME OF WITNESS J. H. HARRIS	
82. NAME OF WITNESS J. H. HARRIS		83. NAME OF WITNESS J. H. HARRIS		84. NAME OF WITNESS J. H. HARRIS	
85. NAME OF WITNESS J. H. HARRIS		86. NAME OF WITNESS J. H. HARRIS		87. NAME OF WITNESS J. H. HARRIS	
88. NAME OF WITNESS J. H. HARRIS		89. NAME OF WITNESS J. H. HARRIS		90. NAME OF WITNESS J. H. HARRIS	
91. NAME OF WITNESS J. H. HARRIS		92. NAME OF WITNESS J. H. HARRIS		93. NAME OF WITNESS J. H. HARRIS	
94. NAME OF WITNESS J. H. HARRIS		95. NAME OF WITNESS J. H. HARRIS		96. NAME OF WITNESS J. H. HARRIS	
97. NAME OF WITNESS J. H. HARRIS		98. NAME OF WITNESS J. H. HARRIS		99. NAME OF WITNESS J. H. HARRIS	
100. NAME OF WITNESS J. H. HARRIS		101. NAME OF WITNESS J. H. HARRIS		102. NAME OF WITNESS J. H. HARRIS	

1105

CERTIFICATE OF DEATH

Reg. Dist. No.

14052

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b 11 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henson Middle Henry Last Henry		4. DATE OF DEATH Month Dec. Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 1866
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	11. IF UNDER 24 HRS. Months 10 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Abraham Henry		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Elizabeth Henry - Wife		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia with abscess formation 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic nephrosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 Dec. 1959 , 19____ to 27 Dec. , 1959, that I last saw the deceased alive on 27 Dec. 1959 , 19____, and that death occurred on 6:50 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Till Bergmann		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Till Bergmann, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-31-59	22b. DATE THEREOF 12-31-59	22c. NAME OF CEMETERY OR CREMATORY Holy Family Cem.	22d. LOCATION (City, town, or county) (State) Woodman Md
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Washington		24a. REC'D BY REGISTRAR JAN 4 60	
ADDRESS 4925 Dean Ave NE		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11052

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

EDUCATIONAL BACKGROUND

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

HOME

EDUCATION

RELIGION

EDUCATION

EDUCATIONAL BACKGROUND

EDUCATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

HOME

EDUCATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

HOME

EDUCATION

CERTIFICATE OF DEATH

Reg. Dist. No. 14027

14053

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 15 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Willard Dewey Hook				4. DATE OF DEATH Month Day Year Dec. 25 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 17, 1898	
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) County Pub. Works Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foremen				10b. KIND OF BUSINESS OR INDUSTRY County Pub. Works Maryland			
13. FATHER'S NAME Samuel Pinkney Hook				14. MOTHER'S MAIDEN NAME Annie Eliza Duley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XN Unknown				16. SOCIAL SECURITY NO. XXXXXXXXXX			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Chronic Bilateral Pyelonephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 600.0				INTERVAL BETWEEN ONSET AND DEATH 7 Days 3 Mos			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 hr , 19 57 to Dec. 25 , 19 59 , that I last saw the deceased alive on 24 Dec , 19 59 , and that death occurred at 3:40 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Upper Marlboro, Md. 12/25/59			
PHYSICIAN'S NAME (Type) Dr. Robert Sasscer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/59		22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		22d. LOCATION (City, town, or county) (State) Croom Md.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]				24a. REC'D BY REGISTRAR DEC 30 '59		24b. REGISTRAR'S SIGNATURE [Signature]	
25. Itchies Bros. Funeral Home -				Upper Marlboro, Md.			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14053

THE STATE OF TEXAS

1903

County of ...
State of Texas
I, the undersigned, Clerk of the County of ...
do hereby certify that the within and foregoing is a true and correct copy of the ...
as the same appears from the records of the County of ...
in the year of our Lord one thousand nine hundred and three.
Witness my hand and the seal of said County at the City of ...
this ... day of ... A.D. 1903.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14106

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14028

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 381</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Victor</u> Middle <u>Arthur</u> Last <u>Horton</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 26, 1907</u>	
9. AGE (In years last birthday) <u>52 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Road Builder Road Building</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Arthur A. Horton</u>				14. MOTHER'S MAIDEN NAME <u>Eva Crouch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1923-1925</u>				16. SOCIAL SECURITY NO. <u>2-21-36-6471</u>			
17. INFORMANT <u>Marcelle Virgin Horton, same as *</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		Month, Day, Year <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-20-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Synchburg, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.M. Chambers Co Inc, Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>DEC 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

14054

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel (West)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel Sanitarium</u>		d. STREET ADDRESS <u>Maple Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>M.</u> Last <u>Howard</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Reynolds</u>		14. MOTHER'S MAIDEN NAME <u>Anne Cochran</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. C. Ostmann - Maple Ave. - West Laurel - Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>two weeks</u> <u>Many years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 28, 1959</u> to <u>Dec. 20, 1959</u> that I last saw the deceased alive on <u>Dec 19</u> , 19 <u>59</u> , and that death occurred at <u>12:20</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jesse C. Coggins</u> M.D.		ADDRESS (Street, city or town, state) <u>Laurel Sanitarium</u> DATE SIGNED <u>12/20/59</u>	
PHYSICIAN'S NAME (Type) <u>Jesse C. Coggins M.D.</u>		<u>Laurel Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/23/50</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. K. Huntemann & Son</u>		24a. REC'D BY REGISTRAR <u>DEC 23 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1906

[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. There are also checkboxes for "Stillborn" and "Fetus" and a section for "Medical History".]

1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14055

CERTIFICATE OF DEATH

14030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 7 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle G Last Jackman		4. DATE OF DEATH Month Dec. Day 7 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1873
9. AGE (In years less than day) 86 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	11. IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Joshua Jackman		14. MOTHER'S MAIDEN NAME Aurelia Hunt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-09-5763A	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastrointestinal hemorrhage 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the colon (adenocarcinoma) approx 1 yr. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1 , 19 58 to Dec. 7 , 19 59 , that I last saw the deceased alive on Dec. 7 , 19 59 , and that death occurred at 6:55A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William Brainin M.D.		ADDRESS (Street, city or town, state) 6124 Central Ave	
PHYSICIAN'S NAME (Type) WM BRAININ		DATE SIGNED 12/7/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		22d. LOCATION (City, town, or county) (State) Bladensburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Co Inc		ADDRESS Washington D.C.	
24a. REC'D BY REGISTRAR DEC 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

2

1

CERTIFICATE OF DEATH

1905

NAME OF DECEASED

AGE

SEX

10

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF PHYSICIAN

NAME OF SURGEON

NAME OF CORONER

NAME OF JURY

NAME OF JURY

NAME OF JURY

NAME OF JURY

NAME OF JURY

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14056

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eheverly				c. LENGTH OF STAY IN 1b 7 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (Baby Boy) John Carroll Jackson				4. DATE OF DEATH Month Dec. Day 1 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1959	
9. AGE (In years lost birthday) — yrs.		10. IF UNDER 1 YEAR Months 8 Yrs 18		11. IF UNDER 24 HRS. Hours 20 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None--Infant				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Eugene Jackson				14. MOTHER'S MAIDEN NAME Barbara Ann Sparrough			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mother Barbara Ann Jackson, 5107 Edgewood Rd.,				Address College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Asphyxia DUE TO (c) with jaundice & ecchymosis & head face presentation							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 25 , 19 59 , to Dec. 1 , 19 59 , that I last saw the deceased alive on 12/1 , 19 59 , and that death occurred at 8 A. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas A. Christensen				ADDRESS (Street, city or town, state) 6905 Back Blvd			
DATE SIGNED 12/1/59							
PHYSICIAN'S NAME (Type) Dr. Thomas A. Christensen				College Park, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				ADDRESS 24a. REC'D BY REGISTRAR DATE DEC 3 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077245XU2

14052

CERTIFICATE OF DEATH

Full name of deceased: [illegible]

Age: [illegible] Sex: [illegible]

Place of birth: [illegible]

Date of death: [illegible]

Place of death: [illegible]

Signature of Registrar: [illegible]

Signature of Medical Officer: [illegible]

Signature of Coroner: [illegible]

Witness: [illegible]

Witness: [illegible]

Witness: [illegible]

2027171XW6

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of medical officer: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14038

14058

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>471-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ADSACORDIES REST HOME</u>		d. STREET ADDRESS <u>5510 16th St NW</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>BARTELS</u> Last <u>JOHNSON</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 13, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE M ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral hemorrhage</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/10</u> , 19 <u>59</u> , to <u>12/21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/20</u> , 19 <u>59</u> , and that death occurred at <u>5:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4410 74th Ave Londoner Hills, Md</u> DATE SIGNED <u>12/21/59</u> ACTUAL SIGNATURE <u>F.E. MUSSER</u> M.D. PHYSICIAN'S NAME (Type) <u>F.E. MUSSER</u>			
22a. BURIAL, CREMATION, or other disposition (Specify) <u>12-23-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,7,8,9 - Film G254-1-6/60-mb

CERTIFICATE OF DEATH

Items 8,9,13,14 Film G254 1-8-60 et

Reg. Dist. No.

14054

14059

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorcy Road SE</u>		c. LENGTH OF STAY IN 1b <u>CLINTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges County Rest Home</u>		d. STREET ADDRESS <u>St. John's Catholic Church</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Johnson</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cleaning</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown ??</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Dorcy Rd., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute non specific Colitis</u> <u>571.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arterio Sclerosis (Senile)</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>natural Causes</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1st</u> , 19 <u>59</u> , to <u>Dec 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 26</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>5440 Silver Hill Rd SE</u> DATE SIGNED <u>Washington 28 Dec</u>			
ACTUAL SIGNATURE <u>Paul C. Van Natta</u> M.D.			
PHYSICIAN'S NAME (Type) <u>PAUL C. VAN NATTA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-30-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John</u>	22d. LOCATION (City, town, or county) (State) <u>Clinton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle E. Salline</u>		ADDRESS <u>H 339 Hunt Pl., N.E.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

14013

1. PLACE OF DEATH a. COUNTY PRINCE George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE c. LENGTH OF STAY IN lb 2 yr.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1761 MASS. AVE. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ETTA VIOLA Johnson				4. DATE OF DEATH Month Day Year Dec 28 1959			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 3 - 1974	
9. AGE (In years last birthday) 85 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILLINERY		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md, USA		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME FRANKLIN A Neale			
14. MOTHER'S MAIDEN NAME HANNAH V. SAIGEE				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. NO				17. INFORMANT Address SR. Maureen Therese - Carroll Manor			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS C MYOCARDIAL INFARCTION 585 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHOLECYSTITIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 2 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Maryland		20h. (State) Maryland	
21. I certify that I attended the deceased from MAR 26 , 19 58 , to DEC 28 , 19 59 , that I last saw the deceased alive on DEC 27 , 19 59 , and that death occurred at 7 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 322 - H ST NE DATE SIGNED 12/28/59 ACTUAL SIGNATURE Thomas F Collins M.D. PHYSICIAN'S NAME (Type) THOMAS F COLLINS MD 322 - H ST NE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS Ellsworth Armacost - 4600 Liberty Hgts. Ave.				24a. REC'D BY REGISTRAR DEC 30 '59		24b. REGISTRAR'S SIGNATURE Charles E. House	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

[Faint, mostly illegible text from the reverse side of the document is visible through the paper. Discernible words include:]

... of ...
... born ...
... died ...
... cause of death ...
... signed ...
... registrar ...

14060

CERTIFICATE OF DEATH

Reg. Dist. No.

14036

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			
c. LENGTH OF STAY IN 1b app. 50 min.				d. STREET ADDRESS 327 Thomas Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Ieland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle L. Last JOHNSTON				4. DATE OF DEATH Month December Day 28 Year 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/6/1892	
9. AGE (In years last birthday) 67 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired model maker		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Leasure Johnston			
14. MOTHER'S MAIDEN NAME Hamah Rouch				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown			
16. SOCIAL SECURITY NO.				17. INFORMANT Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelogenous Leukemia Chronic 2041 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 1959 to December 28, 1959 , that I last saw the deceased alive on Dec 28, 1959 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R.C. Wingfield, M.D.				DATE SIGNED Dec 28, 1959			
PHYSICIAN'S NAME (Type) R.C. Wingfield, M.D.				22a. NAME OF CEMETERY OR CREMATORY Burtonville Md			
22b. DATE THEREOF 12/31/59				22c. LOCATION (City, town, or county) (State) Burtonville Md			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Hume				24a. REC'D BY REGISTRAR DATE JAN 4 '60			
24b. REGISTRAR'S SIGNATURE Arthur L. Hume							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1000

Form 100-100

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10-15-1900"]		PLACE OF BIRTH [Faint text, possibly "New York City"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		DATE OF DEATH [Faint text, possibly "10-20-1945"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]	



This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed with the local health department and a copy sent to the State Department of Health.

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 14061
 CERTIFICATE OF DEATH

14038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Annapolis Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Jones		4. DATE OF DEATH Month Dec. Day 7 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Dec. 1959
9. AGE (In years last birthday) yrs. 6		10. IF UNDER 1 YEAR Months 6 Days 6 Hours 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Micheal E=		14. MOTHER'S MAIDEN NAME Beryl J MARSHIO	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 Respiratory Failure DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 Dec. 1959 to 7 Dec. 1959 , that I last saw the deceased alive on 7 Dec. 1959 , and that death occurred at 3,30A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William R. Greco M.D.		ADDRESS (Street, city or town, state) 8303 Rosette Lane DATE SIGNED 12/8/59	
PHYSICIAN'S NAME (Type) Dr. William Greco, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 12/9/59	22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly Md	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn Jr Administrator.		24a. REC'D BY REGISTRAR DEC 14 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hanes

CERTIFICATE OF DEATH

1908

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE AT BIRTH

SEX AT BIRTH

RACE AT BIRTH

EDUCATION AT BIRTH

OCCUPATION AT BIRTH

RELIGION AT BIRTH

MARRIAGE AT BIRTH

CHILDREN AT BIRTH

PREVIOUS ILLNESS AT BIRTH

DATE OF DEATH AT BIRTH

PLACE OF DEATH AT BIRTH

CAUSE OF DEATH AT BIRTH

AGE AT DEATH AT BIRTH

SEX AT DEATH AT BIRTH

RACE AT DEATH AT BIRTH

EDUCATION AT DEATH AT BIRTH

OCCUPATION AT DEATH AT BIRTH

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14107

CERTIFICATE OF DEATH

Reg. Dist. No.

14037

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				c. LENGTH OF STAY IN 1b 5 DAYS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, DC				47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) USAF HOSPITAL ANDREWS				d. STREET ADDRESS 1633 MORRIS ROAD, SE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANTHONY Middle L Last JONES		4. DATE OF DEATH Month DECEMBER Day 9 Year 19 59					
5. SEX MALE	6. COLOR OR RACE NEGROID	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 NOVEMBER 1959	9. AGE (In years last birthday) yrs. 1 Months 8 Days Hours Min.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME JARVIS J. JONES				14. MOTHER'S MAIDEN NAME ARDELLE L LAWRENCE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT FATHER		Address SAME AS 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.0 DUE TO Septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diarrhea (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 17 hrs 2 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 Dec, 1959, to 9 Dec, 1959, that I last saw the deceased alive on 9 Dec, 1959, and that death occurred at 11:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF HOSPITAL ANDREWS 9 DECEMBER 1959 ACTUAL SIGNATURE Vincent P Ringrose, Jr. M.D. PHYSICIAN'S NAME (Type) VINCENT P RINGROSE, JR, CAPT, USAF, MC USAF HOSPITAL ANDREWS, WASHINGTON 25, DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-12-59		22c. NAME OF CEMETERY OR CREMATORY PLEASANT PLAINS		22d. LOCATION (City, town, or county) (State) AHOSKIE, NORTH CAROLINA	
23. FUNERAL DIRECTOR'S SIGNATURE B. F. Taylor, 1702 12TH ST, N.W. D.C.				24a. REC'D BY REGISTRAR DATE DEC 14 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each page. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050243XV4

CERTIFICATE OF DEATH

11105

<p>NAME OF DECEASED JAMES EARL RAY DATE OF BIRTH JAN 19 1928 PLACE OF BIRTH MOBILE, ALABAMA</p>		<p>DATE OF DEATH APR 4 1968 PLACE OF DEATH MEMPHIS, TENNESSEE</p>	
<p>SEX MALE RACE WHITE</p>		<p>EDUCATION HIGH SCHOOL OCCUPATION MINISTER</p>	
<p>US BIRTH YES ALIEN NO</p>		<p>US CITIZENSHIP YES ALIEN NO</p>	
<p>DATE OF DEATH APR 4 1968 TIME OF DEATH 10:00 PM</p>		<p>PLACE OF DEATH MEMPHIS, TENNESSEE NAME OF HOSPITAL MEMPHIS GENERAL HOSPITAL</p>	
<p>CAUSE OF DEATH HEART DISEASE MYOCARDIAL INFARCTION</p>		<p>IMMEDIATE CAUSE HEART DISEASE MYOCARDIAL INFARCTION</p>	
<p>UNDERLYING CAUSE HEART DISEASE MYOCARDIAL INFARCTION</p>		<p>IMMEDIATE CAUSE HEART DISEASE MYOCARDIAL INFARCTION</p>	
<p>DATE OF DEATH APR 4 1968 TIME OF DEATH 10:00 PM</p>		<p>PLACE OF DEATH MEMPHIS, TENNESSEE NAME OF HOSPITAL MEMPHIS GENERAL HOSPITAL</p>	
<p>CAUSE OF DEATH HEART DISEASE MYOCARDIAL INFARCTION</p>		<p>IMMEDIATE CAUSE HEART DISEASE MYOCARDIAL INFARCTION</p>	
<p>UNDERLYING CAUSE HEART DISEASE MYOCARDIAL INFARCTION</p>		<p>IMMEDIATE CAUSE HEART DISEASE MYOCARDIAL INFARCTION</p>	



THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A LICENSED NURSE. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR A LICENSED NURSE WHO IS NOT A RESIDENT OF THE STATE OF MARYLAND. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR A LICENSED NURSE WHO IS NOT A MEMBER OF THE MARYLAND MEDICAL SOCIETY OR THE MARYLAND NURSING SOCIETY. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR A LICENSED NURSE WHO IS NOT A MEMBER OF THE MARYLAND MEDICAL SOCIETY OR THE MARYLAND NURSING SOCIETY.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14039

Reg. Dist. No.

14014

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			c. LENGTH OF STAY IN 1b 8 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4100 Oglethorpe Street				d. STREET ADDRESS 4100 Oglethorpe Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Frank Jacob Kiess				4. DATE OF DEATH Month Day Year December 1, 19 59				
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-26-88		
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Kiess				14. MOTHER'S MAIDEN NAME Ellen L. Fehr				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W.1 577-10-8789A		17. INFORMANT Address Ellen S. Kiess; same address as # 2.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause lost. DUE TO</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)</p>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		December 2, 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/59		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE DEC 4 '59		
				24b. REGISTRAR'S SIGNATURE Arthur S. Harris				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14062

14040

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN TB <u>Deadman</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Capital Heights</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>822 - 59th Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry Lee King</u> First Middle Last				4. DATE OF DEATH <u>Dec 19 1959</u> Month Day Year			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 21, 1925</u>	9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>West of Columbia U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Rufus King</u>				14. MOTHER'S MAIDEN NAME <u>Laurel Ethel Walton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWII</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-10-5998</u>		17. INFORMANT <u>Helen M. Brady Upper Marlboro Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Universal burns of body, second degree</u> (c) <u>916.0</u> DUE TO cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was sleeping in room that caught on fire</u>					
20c. TIME OF INJURY Month, Day, Year <u>3:45 a.m. 12-19-1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Capital Heights</u>	(County) <u>Bg.</u>	(State) <u>Md</u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec 19, 1959</u>			
22a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 23, 1959</u>		22c. NAME OF CEMETERY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO., Riverdale, Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

14063

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS P.O. Box Box 366			
3. NAME OF DECEASED (Type or print) First Betty= Middle Pauline Last Knauer				4. DATE OF DEATH Month Dec. Day 8 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 June 1938		9. AGE (In years last birthday) yrs. 21	IF UNDER 1 YEAR Months 21	IF UNDER 24 HRS. Days 8 Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Construction Co		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? Washington D. C.	
13. FATHER'S NAME Herman Knauer				14. MOTHER'S MAIDEN NAME Ruth B Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT Address Herman Knauer Beltsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mass. left intracerebral hemorrhage DUE TO 414X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sub acute bacterial endocarditis DUE TO (c) Rheumatic Heart disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct , 19 59 , to Dec , 19 59 , that I lost saw the deceased alive on Dec 8 , 19 59 , and that death occurred at 7:40A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. W. Etienne		M.D. 4713 Berwyn Blvd		ADDRESS (Street, city or town, state) College Park, Md		DATE SIGNED 12/8/59	
PHYSICIAN'S NAME (Type) Dr. W. Etienne., Md.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 10, 1959		22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Bowie Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE DEC 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knauer	

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CERTIFICATE OF DEATH

Reg. Dist. No.

14064

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg Md.		c. LENGTH OF STAY IN 1b 15 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4101 55th avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle A. Last KNEFELY		4. DATE OF DEATH Month DEC Day 25 Year 1959	
5. SEX MALE	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JAN 3, 1889
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Forman		10b. KIND OF BUSINESS OR INDUSTRY University of Md	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Knefely		14. MOTHER'S MAIDEN NAME Mary E Leighsier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20b. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that I attended the deceased from July , 19 56 , to Dec 25 , 19 59 that I last saw the deceased alive on Dec 23 , 19 59 , and that death occurred at 10 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William D Rosson		ADDRESS (Street, city or town, state) 5304 ANNAPOLIS ROAD DATE SIGNED 12/25/59	
PHYSICIAN'S NAME (Type) William D. Rosson		BLADENSBURG, MARYLAND.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 28, 1959	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
22d. LOCATION (City, town, or county) (State) Baltimore Maryland		22e. REC'D BY REGISTRAR DEC 28 '59	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		23b. REGISTRAR'S SIGNATURE Arthur S. Kline	
ADDRESS Hyattsville Md.			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14065

14371

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley				c. LENGTH OF STAY IN 1b 34 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle T. Last Kreuter				4. DATE OF DEATH Month 12-30- Day 19 Year 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-1-01	
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK MAN				10b. KIND OF BUSINESS OR INDUSTRY RAILWAY EXPRESS			
13. FATHER'S NAME CHARLES KREUTER				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. UNKNOWN			
17. INFORMANT SARAH L. KREUTER				Address HILLSIDE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Sumo pneumonia - Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Acute schist AF de DUE TO (c) Acute schist AF de							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11-26 , 19 58 , to Dec 30 19 59 that I last saw the deceased alive on Dec 30 19 59 , and that death occurred at 3:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon Levitsky				ADDRESS (Street, city or town, state) DATE SIGNED 3408 RHODE ISLAND AVE 12/31/59			
PHYSICIAN'S NAME (Type) Dr. Leon Levitsky				M.D. MT RAINIER, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 1/2/1960			
22c. NAME OF CEMETERY OR CREMATORY WASH NATL CEM.				22d. LOCATION (City, town, or county) (State) SUITLAND B. PR. 6006, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				24a. REC'D BY REGISTRAR DATE JAN 7 '60			
ADDRESS WASH. D.C.				24b. REGISTRAR'S SIGNATURE Arthur S. Kram			

1231

REPORT OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14066 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 96 Kingston Park			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Johnnie Middle Radford Last Lane				4. DATE OF DEATH Month December Day 4 Year 1959			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 8, 1914	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic inspector				10b. KIND OF BUSINESS OR INDUSTRY U.S.Govt.		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES LANE				14. MOTHER'S MAIDEN NAME ERTTA NICTOLS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes U.S.N				16. SOCIAL SECURITY NO. 215-16-6639			
17. INFORMANT Mary Anna Lane; same address as # 2.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 442X (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 4, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 12-8-59		22c. NAME OF CEMETERY OR CREMATORY St. Marys		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Connolly 418 Eastern Blvd.				24a. REC'D BY REGISTRAR DEC 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
1962 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. RACE [REDACTED]	
5. DATE OF BIRTH [REDACTED]		6. PLACE OF BIRTH [REDACTED]	
7. DATE OF DEATH [REDACTED]		8. PLACE OF DEATH [REDACTED]	
9. TIME OF DEATH [REDACTED]		10. CAUSE OF DEATH [REDACTED]	
11. MANNER OF DEATH [REDACTED]		12. SIGNATURE OF EXAMINER [REDACTED]	
13. SIGNATURE OF WITNESS [REDACTED]		14. SIGNATURE OF CORONER [REDACTED]	
15. SIGNATURE OF JURY [REDACTED]		16. SIGNATURE OF JURY [REDACTED]	
17. SIGNATURE OF JURY [REDACTED]		18. SIGNATURE OF JURY [REDACTED]	
19. SIGNATURE OF JURY [REDACTED]		20. SIGNATURE OF JURY [REDACTED]	
21. SIGNATURE OF JURY [REDACTED]		22. SIGNATURE OF JURY [REDACTED]	
23. SIGNATURE OF JURY [REDACTED]		24. SIGNATURE OF JURY [REDACTED]	
25. SIGNATURE OF JURY [REDACTED]		26. SIGNATURE OF JURY [REDACTED]	
27. SIGNATURE OF JURY [REDACTED]		28. SIGNATURE OF JURY [REDACTED]	
29. SIGNATURE OF JURY [REDACTED]		30. SIGNATURE OF JURY [REDACTED]	
31. SIGNATURE OF JURY [REDACTED]		32. SIGNATURE OF JURY [REDACTED]	
33. SIGNATURE OF JURY [REDACTED]		34. SIGNATURE OF JURY [REDACTED]	
35. SIGNATURE OF JURY [REDACTED]		36. SIGNATURE OF JURY [REDACTED]	
37. SIGNATURE OF JURY [REDACTED]		38. SIGNATURE OF JURY [REDACTED]	
39. SIGNATURE OF JURY [REDACTED]		40. SIGNATURE OF JURY [REDACTED]	
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47. SIGNATURE OF JURY [REDACTED]		48. SIGNATURE OF JURY [REDACTED]	
49. SIGNATURE OF JURY [REDACTED]		50. SIGNATURE OF JURY [REDACTED]	
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53. SIGNATURE OF JURY [REDACTED]		54. SIGNATURE OF JURY [REDACTED]	
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57. SIGNATURE OF JURY [REDACTED]		58. SIGNATURE OF JURY [REDACTED]	
59. SIGNATURE OF JURY [REDACTED]		60. SIGNATURE OF JURY [REDACTED]	
61. SIGNATURE OF JURY [REDACTED]		62. SIGNATURE OF JURY [REDACTED]	
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67. SIGNATURE OF JURY [REDACTED]		68. SIGNATURE OF JURY [REDACTED]	
69. SIGNATURE OF JURY [REDACTED]		70. SIGNATURE OF JURY [REDACTED]	
71. SIGNATURE OF JURY [REDACTED]		72. SIGNATURE OF JURY [REDACTED]	
73. SIGNATURE OF JURY [REDACTED]		74. SIGNATURE OF JURY [REDACTED]	
75. SIGNATURE OF JURY [REDACTED]		76. SIGNATURE OF JURY [REDACTED]	
77. SIGNATURE OF JURY [REDACTED]		78. SIGNATURE OF JURY [REDACTED]	
79. SIGNATURE OF JURY [REDACTED]		80. SIGNATURE OF JURY [REDACTED]	
81. SIGNATURE OF JURY [REDACTED]		82. SIGNATURE OF JURY [REDACTED]	
83. SIGNATURE OF JURY [REDACTED]		84. SIGNATURE OF JURY [REDACTED]	
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87. SIGNATURE OF JURY [REDACTED]		88. SIGNATURE OF JURY [REDACTED]	
89. SIGNATURE OF JURY [REDACTED]		90. SIGNATURE OF JURY [REDACTED]	
91. SIGNATURE OF JURY [REDACTED]		92. SIGNATURE OF JURY [REDACTED]	
93. SIGNATURE OF JURY [REDACTED]		94. SIGNATURE OF JURY [REDACTED]	
95. SIGNATURE OF JURY [REDACTED]		96. SIGNATURE OF JURY [REDACTED]	
97. SIGNATURE OF JURY [REDACTED]		98. SIGNATURE OF JURY [REDACTED]	
99. SIGNATURE OF JURY [REDACTED]		100. SIGNATURE OF JURY [REDACTED]	

14015

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth S. Middle Leahy Last Leahy		4. DATE OF DEATH Dec. 12, 1959 Month Dec. Day 12 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/89
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Massachusetts	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME David Sullivan		14. MOTHER'S MAIDEN NAME Katherine Cuddihy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 226-38-8904	
17. INFORMANT David E. Leahy		18. ADDRESS 6101 16th St. N.W. Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aneurysm Rt. Temporal Artery DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 18 hrs. 5 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 51 , to Dec 12 , 19 59 that I last saw the deceased alive on Dec 12 , 19 59 , and that death occurred at 11 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Francis T. Coleman M.D.		ADDRESS (Street, city or town, state) 5315-16th St. N.W. Wash D.C. DATE SIGNED 12/13/59	
PHYSICIAN'S NAME (Type) Francis T. Coleman			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/15/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR DEC 16 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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14067

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12, 13, 14 Film G254 1-13-60 et

CERTIFICATE OF DEATH

Reg. Dist. No. 14045

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 2 1/2 Hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville d. STREET ADDRESS 6309 Muirkirk Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lyle Lesane		4. DATE OF DEATH Month Day Year Dec. 6 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-4-59
9. AGE (In years last birthday) 3		10. IF UNDER 1 YEAR Months Days Hours Min. 3 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Solmon Lesane		14. MOTHER'S MAIDEN NAME Helen Marshall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Rb. & Empyema 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 6 , 19 59 , to Dec. 6 , 1959, that I last saw the deceased alive on Dec. 6 , 19 59 , and that death occurred at 2:45 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. L. ETIENNE M.D. 4713 Broadway St. PHYSICIAN'S NAME (Type) W. L. ETIENNE College Park Md 11/14/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-12-59		22b. NAME OF CEMETERY OR CREMATORY New Harmony	
22c. LOCATION (City, town, or county) md.		22d. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frazier's Funeral Home ADDRESS 389 Rte. 1, Beltsville		24a. REC'D BY REGISTRAR DATE DEC 14 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2077366XVS

Birth certificate filed 9/3/59 under
Lyle Donnel Marshall -

(Mother gave different information on
each admission to the hospital)

14019

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges Co. 4303 Russell Ave. Mt. Rainier MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1 d. STREET ADDRESS 4303 Russell Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK W. LOEFFLER		4. DATE OF DEATH Month Day Year Dec. 2. 1959	
5. SEX Male	6. COLOR OR RACE Wk	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-6-1894
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheetmetal Worker		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Hanover, Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilhelm Loeffler		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no -----		16. SOCIAL SECURITY NO. 578 09 0272	
17. INFORMANT Address Emmy Loeffler, 4303 Russell Ave.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Carcinoma of stomach (Inoperable) Md. Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 3, 1959, to Dec. 2, 1959, that I last saw the deceased alive on Nov. 14, 1959, and that death occurred at 3 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED HUGO EINSTEIN M.D. 2021 G St. N.W. Dec. 2. 59			
ACTUAL SIGNATURE HUGO EINSTEIN		PHYSICIAN'S NAME (Type) HUGO EINSTEIN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 12-5-59		22b. DATE THEREOF 12-5-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Paulsen Sons, 1756 P Ave. N.W. D.C.		24. REC'D BY REGISTRAR DATE DEC 7 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hays			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH POLICY

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14068
CERTIFICATE OF DEATH

Reg. Dist. No. 14047

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Fairmont Heights		d. STREET ADDRESS 1105 60th Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Luckett		4. DATE OF DEATH Month Day Year December 9 19 59					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 4, 1959	
9. AGE (In years lost birthday) yrs. Months Days 6 6		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME James Nickles		14. MOTHER'S MAIDEN NAME Christine Luckett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO prematurity Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) atelectasis (c)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 4, 1959, to Dec. 9, 1959, that I last saw the deceased alive on Dec. 9, 1959, and that death occurred at 6:05 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 12/10/59			
ACTUAL SIGNATURE Thomas A. Christensen		M.D.		6905 Baltimore Ave.		College Park, Md.	
PHYSICIAN'S NAME (Type) Dr Thomas A. Christensen, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 12/16/59		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator		ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 21 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

14048

14069

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS Simpsonville 13X-2			
3. NAME OF DECEASED (Type or print) First Racheal Middle Macgrill Last Macgrill				4. DATE OF DEATH Month December Day 2 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 25, 1881	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John R. Clarke				14. MOTHER'S MAIDEN NAME Susan OWEN Dorsey Owings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure, Shock 2 days 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Intestinal obstruction, Diabetes 2 weeks (c) Intestinal obstruction, Diabetes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11-27 , 19 59 , to 12-2 , 19 59 , that I last saw the deceased alive on 12-2 , 19 59 , and that death occurred at 11 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 305 Prince George Street, Laurel, Maryland DATE SIGNED							
ACTUAL SIGNATURE Idolo Pierandrei M.D. 305 Prince George Street, Laurel, Maryland							
PHYSICIAN'S NAME (Type) Idolo Pierandrei, M.D. 305 Prince George Street, Laurel, Maryland. 12/3/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-4-59		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE DEC 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14049

Reg. Dist. No.

14108

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND				c. LENGTH OF STAY IN 1b 3 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 3134 Parkway Terr. Dr. Apt #6			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle GARRET Last MADDEN				4. DATE OF DEATH Month December Day 26 Year 19 59			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 September 1959	
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months 3 Days 19 Hours Min. 		11. BIRTHPLACE (State or foreign country) Maryland Prince George County		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A			
13. FATHER'S NAME James D. Madden				14. MOTHER'S MAIDEN NAME Constance W. SCHROEDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Father 3134 Parkway Derr Dr. Apt 6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown, pending Autopsy Report // 493 X DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____ 21. I certify that I attended the deceased from 26 Dec , 19 59 , to 26 Dec , 19 59 , that I last saw the deceased alive on DOA 26 Dec , 19 59 , and that death occurred at 0841 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 26 Dec 59 ACTUAL SIGNATURE Sanford L. Billet M.D. USAF Hospital Andrews, Andrews Air Force Base Prince George County, Maryland PHYSICIAN'S NAME (Type) SANFORD L. BILLET, Capt USAF MC 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12/28/59 22c. NAME OF CEMETERY OR CREMATORY Auburn, New York 22d. LOCATION (City, town, or county) (State) 816 M Street, N. E. Wash. 2, D. C. 24a. REC'D BY REGISTRAR DATE DEC 28 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Evans							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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14109

CERTIFICATE OF DEATH

Reg. Dist. No.

14050

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base				c. LENGTH OF STAY IN 1b USAF Hospital Andrews, Andrews AFB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews, Andrews AFB				d. STREET ADDRESS 412 60th Avenue, Capitol Heights			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizebeth MALLOY				4. DATE OF DEATH Month Day Year December 26 19 59			
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 December 1959	9. AGE (In years last birthday) yrs. 9-10	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John X. Malloy				14. MOTHER'S MAIDEN NAME Margaret Jean HARMON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Address (Birth Certificate)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 340.3 MENINGITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 36 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Premature birth 4/16 502							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 DEC 1959 , to 26 DEC 1959 , that I last saw the deceased alive on 26 DEC 1959 , and that death occurred at 0148 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF Hospital Andrews 26 Dec 59 Andrews Air Force Base Washington 25, D. C.							
ACTUAL SIGNATURE John A. Moore				M.D. USAF Hospital Andrews			
PHYSICIAN'S NAME (Type) JOHN A. MOORE, Capt USAF MC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/59		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Boston, Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE Michael J. Rinaldi Rinaldi Funeral Home				ADDRESS 816 H Street, N. E. Washington 2, D. C.		24a. REC'D BY REGISTRAR DATE DEC 28 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Froud			

2050182XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14051

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville (Rural)		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Tony's Texaco, Junction Route #50 & #301		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAUL Middle NATHANIEL Last MARSHALL		4. DATE OF DEATH Month December Day 7th , Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14th, 1935
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 59 Min.	11. BIRTHPLACE (State or foreign country) Washington, D.C.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY School Bldg.	
13. FATHER'S NAME Michael Jermpe Marshall		14. MOTHER'S MAIDEN NAME Elsie Marie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Michael J. Marshall, Route # 1, Mitchellville, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage & Shock 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of chest (c) Shot during holdup of gas station DUE TO stating the underlying cause lost.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)	

MEDICAL CERTIFICATION

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined monner ☐

ACTUAL
SIGNATURE

James I. Boyd, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

12/7/1959

22a. BURIAL, CREMATION, REMOVAL (Specify) 12-11-59	22b. DATE THEREOF 12-11-59	22c. NAME OF CEMETERY OR CREMATORY Adelphi	22d. LOCATION (City, town, or county) (State) Adelphi Va
23. FUNERAL DIRECTOR'S SIGNATURE HS Washington 467-14 St. NW		24a. REC'D BY REGISTRAR DEC 14 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 10 1910
STATE HEALTH DEPT.

MARLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John J. Jones		RESIDENCE 1234 Main St., Baltimore, Md.	
DATE OF DEATH Jan 10, 1910		PLACE OF DEATH Home	
AGE 45		SEX Male	
RACE White		NATURALITY American	
OCCUPATION Clerk		EDUCATION High School	
MARRIAGE Married		SINGLE	
PREVIOUS ILLNESS None		CAUSE OF DEATH Heart Failure	
MANNER OF DEATH Natural		SIGNATURE OF EXAMINER J. H. Smith	
DATE OF EXAMINATION Jan 10, 1910		PLACE OF EXAMINATION Home	
TIME OF EXAMINATION 10:00 AM		SIGNATURE OF DECEASED John J. Jones	
SIGNATURE OF NEXT OF KIN Mary J. Jones		SIGNATURE OF WITNESSES J. H. Smith, M.D.	
DATE OF DEATH Jan 10, 1910		PLACE OF DEATH Home	
AGE 45		SEX Male	
RACE White		NATURALITY American	
OCCUPATION Clerk		EDUCATION High School	
MARRIAGE Married		SINGLE	
PREVIOUS ILLNESS None		CAUSE OF DEATH Heart Failure	
MANNER OF DEATH Natural		SIGNATURE OF EXAMINER J. H. Smith	
DATE OF EXAMINATION Jan 10, 1910		PLACE OF EXAMINATION Home	
TIME OF EXAMINATION 10:00 AM		SIGNATURE OF DECEASED John J. Jones	
SIGNATURE OF NEXT OF KIN Mary J. Jones		SIGNATURE OF WITNESSES J. H. Smith, M.D.	

CERTIFICATE OF DEATH

Reg. Dist. No.

14052

14111

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1307-Balfour Court</u>		d. STREET ADDRESS <u>1307-Balfour Court</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>Mayhew</u> Middle <u>Paul</u> Last		4. DATE OF DEATH <u>12-13th</u> 19 <u>59</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/24, 1890</u>
9. AGE (In years (lost birthday) yrs. <u>69</u>)		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigerator dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>meats</u>	
11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph H. Mayhew</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ann Kelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>579-46-3971</u>	
17. INFORMANT <u>Catherine M. Trevithick</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE PULMONARY EDEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ACUTE MYOCARDIAL INFARCTION (3RD)</u> DUE TO (c) <u>GENERALIZED + CORONARY ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 HOURS</u> <u>2 1/2+ HOURS</u> <u>10 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>56</u> , to <u>13 DEC.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>13 DEC.</u> , 19 <u>59</u> , and that death occurred at <u>5:58 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry R. Wolfe</u>		ADDRESS (Street, city or town, state) <u>905 SHERIDAN ST.</u>	
PHYSICIAN'S NAME (Type) <u>HENRY R. WOLFE M.D.</u>		DATE SIGNED <u>12/13/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Riggs Road, Pr. Georges Co.</u>		22d. LOCATION (City, town, or county) (State) <u>md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u>		ADDRESS <u>mt. Rainier, md.</u>	
DATE <u>DEC 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

1

County of _____
City of _____
I, _____
do hereby certify that _____
born _____
died _____
at _____
on the _____ day of _____
1911.
The cause of death was _____
as certified by _____
Physician.

1

14112

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>PR. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CAMP SPRINGS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CAMP SPRINGS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5250-Auth Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARTHA C. S. MAYHugh</i>		4. DATE OF DEATH Month Day Year <i>Dec. 13 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-28-1874</i>
9. AGE (In years lost birthday) <i>85</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) <i>INDIANA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Miles Shafford</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jane Mc Kay</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —	
17. INFORMANT <i>Alice M. Dibrell</i>		Address <i>5250-Auth Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute congestive heart failure</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) — INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>5 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis, Emphysema</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1, 1949</i> to <i>12-13, 1959</i> , that I last saw the deceased alive on <i>12-13, 1959</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>David S. Gordon</i>		DATE SIGNED <i>5731 23rd Parkway SE 12-13-59</i>	
PHYSICIAN'S NAME (Type) <i>DAVID S. GORDON, M.D.</i>			
22a. DATE OF CREMATION, REINTERMENT (Specify) <i>12-14-59</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Eden Hill Crematory</i>		22d. LOCATION (City, town, or county) (State) <i>Southland Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Bros Funeral Home</i>		24. REG'D BY REGISTRAR <i>WASE 2022</i>	
ADDRESS <i>1611-Good Hope Rd SE</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Harris</i>	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/58

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Geo's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>--</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Roderic Paul Meinhardt</u>		4. DATE OF DEATH Month Day Year <u>December 2 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21, 1959</u>
9. AGE (In years lost birthday) yrs. <u>7</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>--</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Theodore Meinhardt</u>		14. MOTHER'S MAIDEN NAME <u>Marilyn Ruth Ely</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>----</u>	
INFORMANT Address <u>Theodore Meinhardt-Same as above.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>500x</u> DUE TO <u>Asphyx</u> <u>Suffocation</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Acute Toxic - Bunkitis</u> DUE TO <u>Infection</u> (c) <u>Infection</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-2</u> , 19 <u>59</u> to <u>12-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-2</u> , 19 <u>59</u> , and that death occurred at <u>5:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard Ho Dobson</u> M.D.		DATE SIGNED <u>Dec. 2, 59</u>	
PHYSICIAN'S NAME (Type) <u>Richard Ho Dobson</u>		<u>Brandywine, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cheltenham Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cheltenham, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Funeral Home-Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2066264XU7

St Marys
Charles

CERTIFICATE OF DEATH

14055

Reg. Dist. No.

14070

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>				c. LENGTH OF STAY IN 1b <i>50 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Eugene Ieland Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>W.</i> Last <i>Miles</i>				4. DATE OF DEATH Month <i>December</i> Day <i>31</i> Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 17th, 1895</i>	9. AGE (In years lost birthday) <i>64</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Custodian</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Public Schools</i>		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Walter Miles</i>				14. MOTHER'S MAIDEN NAME <i>Minnie Weiskettel</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>unknown</i>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <i>578-20-0896HA</i>		17. INFORMANT <i>Hospital records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (a) <i>Hypertensive Cardiovascular disease</i>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-16</i> , 19 <i>59</i> , to <i>12-30</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12-30</i> , 19 <i>59</i> , and that death occurred at <i>5:45</i> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>4408 Queensbury Road, Riverdale, Md.</i> DATE SIGNED <i>12/31/59</i>							
ACTUAL SIGNATURE <i>D. R. Purdie</i> M.D.				DATE SIGNED <i>12/31/59</i>			
PHYSICIAN'S NAME (Type) <i>D. R. Purdie, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/2/1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Washington Nat'l Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland, Pr. Geo. Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers & Co. Riverdale Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JAN 4 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinn</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

14071

MEDICAL CERTIFICATION

1

CERTIFICATE OF DEATH

Reg. Dist. No.

14072

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 45 Min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale d. STREET ADDRESS 5415 Powhatan Rd., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last MILLER				4. DATE OF DEATH Month December Day 26 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-18-89	
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Southern Dairies		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Marshall M. Miller				14. MOTHER'S MAIDEN NAME Margaret Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578 10 2659		INFORMANT Mrs Faith Miller		Address Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute coronary thrombosis DUE TO (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hr.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-7 , 19 53 to 12-26 , 19 59 that I last saw the deceased alive on 12-26 , 19 59 , and that death occurred at 1:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R.D. BAKER M.D.		M.D. 2513 Breckledge Rd.		ADDRESS (Street, city or town, state) ADDELPHI, M.D.		DATE SIGNED 12-26-59	
PHYSICIAN'S NAME (Type) R.D. BAKER, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 30, 1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) (State) Suitland Md.		24a. REC'D BY REGISTRAR DEC 31 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Kline		24c. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	
24d. ADDRESS Hyattsville, Md.		24e. DATE OF DEATH DEC 26 1959		24f. TIME OF DEATH 1:15 PM		24g. PLACE OF DEATH 5415 Powhatan Rd.,	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

10032

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11-11-19

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13 Film 6254 1-4-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

14058

14073

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 10 yrs. ?			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. STREET ADDRESS Adelphi Rd. & Windon Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George William Middle Montgomery Last				4. DATE OF DEATH Month Dec Day 18 Year 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18 1901	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Anna Robey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes				16. SOCIAL SECURITY NO. Lelia wife as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 452X DUE TO Ruptured aneurysm of left common iliac artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/12 , 19 59 , to 12/18 , 19 59 , that I last saw the deceased alive on 12/18/59 , 19 59 , and that death occurred at 4:05 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm J. Holbrook				ADDRESS (Street, city or town, state) 4500 College Ave., Md.			
COUNTERSIGNED: John S. Matney PHYSICIAN'S NAME (Type) William A. Holbrook				DATE SIGNED 12/18/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/59		22c. NAME OF CEMETERY OR CREMATORY George Wash. Cemetery Prince George Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE DEAL FUNERAL HOME				ADDRESS 4812 Ga Ave NW		24a. REC'D BY REGISTRAR DEC 28 '59	
				24b. REGISTRAR'S SIGNATURE Caroline E. Kenna			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1991 AND STATE DEPARTMENT OF HEALTH-BIRMINGHAM 13

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14059

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				f. STREET ADDRESS Railroad Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Winfield Morgan, Sr.				4. DATE OF DEATH Month Day Year December 14, 19 59			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-28-1901	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Advisor			10b. KIND OF BUSINESS OR INDUSTRY Library of Congress Wash., D.C.			11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Thomas W. Morgan				14. MOTHER'S MAIDEN NAME Laura E. Otto			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Address George W. Morgan; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease DUE TO cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				DATE SIGNED December 14, 1959			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE DEC 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH—BALTIMORE 18

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14075

CERTIFICATE OF DEATH

Reg. Dist. No.

14060

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. LENGTH OF STAY IN 1b <u>adm. June 6-59</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>				d. STREET ADDRESS <u>4890 BATTERY LANE</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BRIDGET</u> Middle <u>GARWAY</u> Last <u>MURPHY</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-5-1875</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>NEW HAMPSHIRE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard - GOLWAY</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET GOLWAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>126-07-3937</u>		17. INFORMANT <u>Hosp. Records LAUREL SANITARIUM</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FIBRILLATION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile dementia (arteriosclerotic)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. <u>5</u> p. m. 19 <u>59</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 6 -</u> , 19 <u>59</u> to <u>Dec - 3 -</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec - 3 -</u> , 19 <u>59</u> , and that death occurred at <u>5:15 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. P. Williams</u>			M.D. <u>LAUREL SANITARIUM</u>			DATE SIGNED <u>12-3-59</u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>			<u>LAUREL MARYLAND</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans. Bur.</u>		22b. DATE THEREOF <u>12-5-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cayoga County, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE DEC 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>John E. Koon</u>	

14076

CERTIFICATE OF DEATH

Reg. Dist. No.

14061

1. PLACE OF DEATH a. COUNTY Prince georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle M Last Nau Sr.		4. DATE OF DEATH Month Dec. Day 23 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 June 1897
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Naval Gun Factory	
11. BIRTHPLACE (State or foreign country) Chicago Illinois		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry Nau		14. MOTHER'S MAIDEN NAME Welhelimina Krause	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Ellen Esther Nau		Address Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Palmar embolus 420.1 DUE TO Saddle embolus aorto Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Myocardial infarction DUE TO (c) Myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemorrhage 12-18-59. Brain fracture 12-23-59.		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 48 hrs 5 days 10 yrs	
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20d. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-28 , 19 55 to 12-23 , 19 59 , that I last saw the deceased alive on 12-23-59 , 19 59 , and that death occurred at 3:00AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John P. Clum		ADDRESS (Street, city or town, state) Hyattsville Md.	
PHYSICIAN'S NAME (Type) Dr. Clum M.D.		DATE SIGNED 12-23-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/26/59	
22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		22d. LOCATION (City, town, or county) (State) Hyattsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
ADDRESS Hyattsville Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-40

CERTIFICATE OF DEATH

14078

2

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is heavily faded and contains illegible text.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14062

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u>		c. LENGTH OF STAY IN 1b <u>2 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Brook's Rest Home</u> 904-68		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Laura</u> First <u>Nichols</u> Middle <u>Nichols</u> Last		4. DATE OF DEATH <u>Dec. 28</u> 19 <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>76</u> yrs.
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>28</u>	11. IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isiah Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Mitchell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral - Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> (c) <u>HYPERTENSIVE C.V.D.</u> INTERVAL BETWEEN ONSET AND DEATH <u>?</u>		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>9049 FRACTURE RT. HIP</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>INJURED IN FALL</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-31</u> , 19 <u>59</u> , to <u>12-28</u> , 19 <u>59</u> that I last saw the deceased alive on <u>12-24</u> , 19 <u>59</u> , and that death occurred at <u>11:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>N. G. Beeldon</u>		ADDRESS (Street, city or town, state) <u>24423 - HUNT PL. NE DC</u>	
PHYSICIAN'S NAME (Type) <u>N. G. Beeldon MD</u>		DATE SIGNED <u>12-24-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12.29.59</u>	22c. NAME OF CEMETERY <u>Nat'l. Harmony Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George's, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. McGuire</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>	
ADDRESS <u>1820 9th St., N.W. Washington, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2113

11

Blank certificate form with horizontal lines for text entry.

(Signature)

CERTIFICATE OF DEATH

Reg. Dist. No.

14077

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 42 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood 33	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 3505 Upshur St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Nutall Last Nutall				4. DATE OF DEATH Month 12- Day 8 Year 19 59			
5. SEX Fem.		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-5-78	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wash. D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Casper Santa				14. MOTHER'S MAIDEN NAME Annie Santa			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. Informant		Address Hospital Records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism with Infarction 450.1 DUE TO Thrombosis of rt. Iliac Vein Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Amputation of Legs DUE TO Gangrene of legs secondary to Arteriosclerosis (c) Diabetes Mellitus							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May , 19 53 , to Dec 7 , 19 59 , that I last saw the deceased alive on Dec 7 , 19 59 , and that death occurred at 7:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon R. Gallin				ADDRESS (Street, city or town, state) 7206 Colesville Rd DATE SIGNED 12/9/59			
PHYSICIAN'S NAME (Type) LEON. L. GALLIN M.D.				West Hyattsville Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/11/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Unithy Haddon - 3831 - Ga An NW.				24a. REC'D BY REGISTRAR DATE DEC 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1917

County of Baltimore

City of Baltimore

On day of

1917

at

in

State of Maryland

That the within and foregoing is a true and correct copy of the original as the same appears from the records of the Registrar of the County of Baltimore, State of Maryland, and that the same is a true and correct copy of the original as the same appears from the records of the Registrar of the County of Baltimore, State of Maryland.

Witness my hand and seal of office this day of

1917

at Baltimore, Maryland

My hand and seal of office

this day of

1917

14078

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 21 Da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Raymond Middle T. Last O'Connell				4. DATE OF DEATH Month Dec. Day 24 Year 19 59			
5. SEX Male		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-23-1897	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) yard-man				10b. KIND OF BUSINESS OR INDUSTRY American Oil Wash, D.C			
13. FATHER'S NAME Frederick H. O'Connell				14. MOTHER'S MAIDEN NAME Agnes W. O'Connell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 578-01-7338			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Carcinoma of the lung. (c) Boney metastases in lung.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 1 , 19 59 , to Dec. 24 , 19 59 , that I last saw the deceased alive on 12-24 , 19 59 , and that death occurred at 9:17 M from the causes and on the date stated above.							
ACTUAL SIGNATURE George Hageage				ADDRESS (Street, city or town, state) 3217-38th Ave Cottage City, Md.			
PHYSICIAN'S NAME (Type) Dr. Geo Hageage M.D.				DATE SIGNED 12-25-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-28-1959		22c. NAME OF CEMETERY OR CREMATORY Congressional		22d. LOCATION (City, town, or county) (State) Washinton, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A Mattingly				ADDRESS Wash, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	
24a. REGISTRAR'S SIGNATURE				DATE DEC 28 '59		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

14065

14016

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>WASH. DC</u> b. COUNTY <u>DISTRICT OF COLUMBIA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>1 YR 3 mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR 4922 LASALLE RD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>3660 CONN. AVE. N.W.</u>							
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>O'CONNOR</u> Last <u>O'CONNOR</u>				4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 16, 1876</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>25</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIRE CHIEF</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DRAINSVILLE VA</u>			
11. BIRTHPLACE (State or foreign country) <u>UNITED STATES</u>				12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>			
13. FATHER'S NAME <u>THOMAS O'CONNOR</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN KENNEDY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>no</u>			
INFORMANT <u>SISTER AGNES PATRICIA-CARROLL MANOR</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>intractable heart failure</u> DUE TO (b) <u>myocardial infarct</u> DUE TO (c) <u>coronary thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 da</u> <u>10 da</u> <u>10+ da</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/22</u> , 19 <u>59</u> , to <u>12/11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/11</u> , 19 <u>59</u> , and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4323 Harvard St. S.E. S.W. 12/11/59</u> DATE SIGNED <u></u> ACTUAL SIGNATURE <u>Richard P. Delaney</u> M.D. PHYSICIAN'S NAME (Type) <u>Richard P. Delaney</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>				24a. REC'D BY REGISTRAR <u>DEC 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. Hines</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

1-1007

DEPARTMENT OF HEALTH - SAN JOSE
COUNTY, CALIFORNIA
I, the undersigned, being a duly qualified medical officer of health for the County of San Jose, California, do hereby certify that
the within and foregoing is a true and correct copy of the original record of death as the same appears in the files of the Department of Health - San Jose, California.
WITNESSED my hand and the seal of said Department at San Jose, California, this 11th day of November, 1967.

Medical Officer of Health
DEPARTMENT OF HEALTH - SAN JOSE
COUNTY, CALIFORNIA

14115

CERTIFICATE OF DEATH

Reg. Dist. No.

14066

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park Hgts			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Deer Park Hgts	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 4510 Temple Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fred Middle V Last Ousley				4. DATE OF DEATH Month December Day 17 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 29, 1909	
9. AGE (In years last birthday) 50 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		11. BIRTHPLACE (State or foreign country) Tenn		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Esco E. Ousley				14. MOTHER'S MAIDEN NAME Maria Warwick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Edith M. Ousley		Address 4510 Temple Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE HEART DISEASE (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 1958 to DECEASED 17 1959, that I last saw the deceased alive on 12/17, 1959, and that death occurred at 6 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED X Bruno Kolega M.D. 4233 ST. BARNABAS RD - SE WASHINGTON 21-D							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/59		22c. NAME OF CEMETERY OR CREMATORY Brookwaller Cem.		22d. LOCATION (City, town, or county) (State) Inskip Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				ADDRESS Wash. DC		24a. REC'D BY REGISTRAR DATE DEC 23 '59	
						24b. REGISTRAR'S SIGNATURE C. L. S. HARRIS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

141116

CERTIFICATE OF DEATH

14067

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 23 DC</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4404 Porter Ave S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Janie Ann Payne</u>		4. DATE OF DEATH <u>12-11-1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 21-1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Sylvester Gant</u>		14. MOTHER'S MAIDEN NAME <u>Janie - unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Janie Teresa Payne</u>		Address <u>4404 Porter Ave Washington 23 DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Coma</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Totally blind and General Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 11) <u>Duration unknown</u> <u>- natural causes</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>none</u> 19 p. m. <u>none</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>58</u> , to <u>Dec 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 10</u> , 19 <u>59</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul C Van Natta</u> M.D.		ADDRESS (Street, city or town, state) <u>5440 Silver Hill Rd SE</u>	
PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATTA</u>		DATE SIGNED <u>Washington 28 DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-15-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Linc o/n Mem.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Rd Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S Washington</u>		ADDRESS <u>467 N st NW</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>O. L. S. Frank</u>	

CERTIFICATE OF DEATH

RECEIVED

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Signature of physician		9. Signature of registrar	
JAMES J. JONES		Male		35		1910-01-15		1945-03-10		Boston, Mass.		Heart Disease		[Signature]		[Signature]	
10. Occupation		11. Marital status		12. Education		13. Religion		14. Race		15. Birthplace		16. Usual residence		17. Usual occupation		18. Usual residence	
Clerk		Married		High School		Catholic		White		New York, N.Y.		Boston, Mass.		Clerk		Boston, Mass.	
19. Name of informant		20. Relationship		21. Address		22. Telephone		23. City		24. State		25. Zip		26. Date of report		27. Signature of informant	
John J. Jones		Son		123 Main St.		555-1234		Boston		Mass.		02101		1945-03-15		[Signature]	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14007

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> 1 1/2 mo.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 College Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9642-Baltimore Boulevard</u>				d. STREET ADDRESS <u>19642-Baltimore Boul.</u>			
3. NAME OF DECEASED (Type or print) <u>Loretta First Middle Last Payne</u>				4. DATE OF DEATH <u>Dec 24 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11-5-10</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Winton Payne</u>				14. MOTHER'S MAIDEN NAME <u>Mittie Barber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>5-77-14-3332</u>		17. INFORMANT <u>Constance Pector</u> Address <u>4571 Riverdale Rd. Riverdale, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-24-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

14007 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		1940		10:00 AM		HOME	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
123 Main St.		Carpenter		Heart Disease		Natural		Coronary Artery Disease		Chest Pain		Medicine	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		CHILDREN		PREVIOUS ILLNESS		HISTORY	
1900		New York		High School		Married		3		None		None	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S RESIDENCE		MOTHER'S RESIDENCE		FAMILY HISTORY	
John J. Jones		Mary J. Jones		Carpenter		Homemaker		123 Main St.		123 Main St.		None	
DATE OF EXAMINATION		PLACE OF EXAMINATION		EXAMINER'S NAME		EXAMINER'S ADDRESS		EXAMINER'S PHONE		EXAMINER'S SIGNATURE		EXAMINER'S TITLE	
1940		Boston		Dr. J. A. Smith		123 Main St.		123-4567		[Signature]		Physician	
DATE OF REPORT		PLACE OF REPORT		REPORTER'S NAME		REPORTER'S ADDRESS		REPORTER'S PHONE		REPORTER'S SIGNATURE		REPORTER'S TITLE	
1940		Boston		John J. Jones		123 Main St.		123-4567		[Signature]		Son	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14069

14117

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8560 River View Road				d. STREET ADDRESS 8560 River View Road			
3. NAME OF DECEASED (Type or print) Gladys Linnia Peters				4. DATE OF DEATH Dec 6 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 27, 1910	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Merchandise		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Philip Gates				14. MOTHER'S MAIDEN NAME Emma Brockner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579620-1400		17. INFORMANT Elizabeth Hutchins Address 8550 River View Road Silver Spring			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12-6-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 9-59		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Broad Creek Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Simmons Bros 1661 9th Hope Rd S E				24a. REC'D BY REGISTRAR DATE DEC 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
RESIDENCE		CITY	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF DEATH	
AGE		SEX	
RACE		RELIGION	
EDUCATION		MARRIAGE	
PREVIOUS ILLNESS		TREATMENT	
HISTORY OF PRESENT ILLNESS		FINDINGS AT AUTOPSY	
LABORATORY EXAMINATIONS		TOXICOLOGY	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS	
DIAGNOSIS		REMARKS	
SIGNATURE OF EXAMINER		DATE	
TITLE		OFFICE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14079
CERTIFICATE OF DEATH

Reg. Dist. No.

14070

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Flora B. Phillips		4. DATE OF DEATH Month Day Year Dec. 21 19 59	
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10- 2- 81
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) GREEN COUNTY, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LINDSAY DULANEY		14. MOTHER'S MAIDEN NAME SUSAN HEADLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address 71 FRANCIS L PHILLIPS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Intra Cerebral Hemorrhage (b) Hypertensive Cardio Vascular Disease 2 yrs (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 8 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 21, 19 59 to Dec. 21, 19 59, that I last saw the deceased alive on Dec. 21, 19 59 and that death occurred at 8:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Comeau M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 3503 Penny St Mt Rainier Md 12/21/59	
PHYSICIAN'S NAME (Type) Dr. Norman Comeau			
22a. BURIAL, CREMATION, REMOVAL (Specify) SHIP RR.		22b. DATE THEREOF 12-24-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery		22d. LOCATION (City, town, or county) (State) Mt Morris Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W. M. Warrell		24a. REC'D BY REGISTRAR DEC 28 '59	
ADDRESS 2121 Chambers Co 1400 Chapin St. N.W.		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

HEALTH-RELATED QUALITY OF LIFE

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458-459

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14118

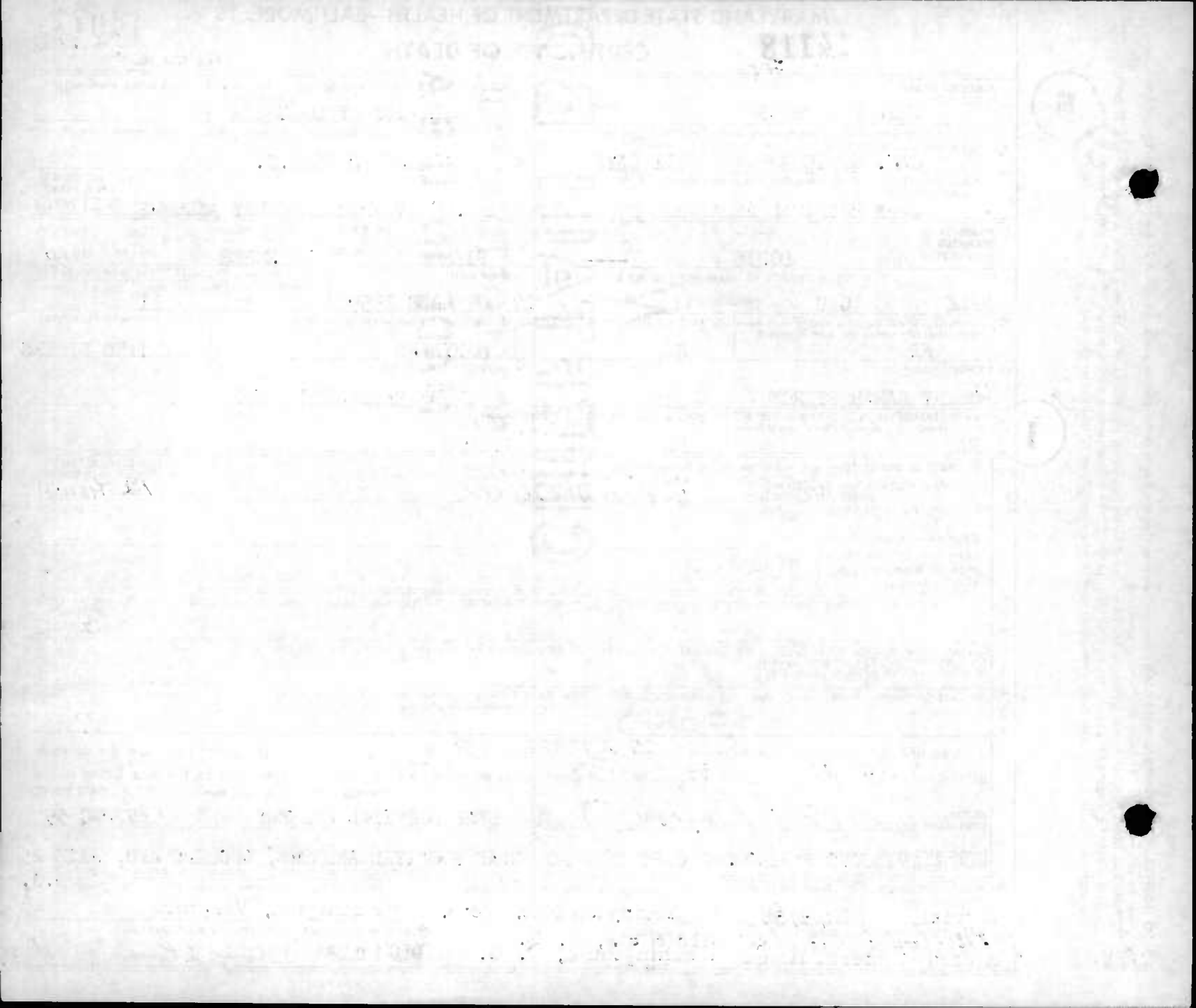
CERTIFICATE OF DEATH

14071

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY (DISTRICT OF COLUMBIA) P.G. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUIS Middle ----- Last PIERCE		4. DATE OF DEATH Month DECEMBER Day 7 Year 1959	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 NOVEMBER 1959
9. AGE (In years lost birthday) yrs. 11		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME ROBERT LAMAR PIERCE		14. MOTHER'S MAIDEN NAME IRENE ELIZABETH MEYER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NA		16. SOCIAL SECURITY NO. NA	
17. INFORMANT FATHER		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 Hours		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 NOVEMBER , 19 59 , to 7 DECEMBER , 19 59 , that I last saw the deceased alive on 7 DECEMBER , 19 59 , and that death occurred at 1230P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Vincent P Ringrose, Jr.		DATE SIGNED 7 DEC 59	
PHYSICIAN'S NAME (Type) VINCENT P RINGROSE CAPT USAF MC		USAF HOSPITAL ANDREWS, ANDREWS AFB, WASH 25	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home		24a. REC'D BY REGISTRAR DEC 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14072

Reg. Dist. No.

14080

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chantilly		c. LENGTH OF STAY IN 1b Dead at home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1409 Tottel Road NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest R Post				4. DATE OF DEATH Dec 2 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 17, 1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Retired		10b. KIND OF BUSINESS OR INDUSTRY DC Water Dept		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Hyacinth Strauff Address Rock Spring Rd Elberta City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec 2, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/5/59		22b. DATE THEREOF 12/5/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Bur		22d. LOCATION (City, town, or county) (State) Suitland Bld. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. Frank Home				ADDRESS 510's W. 1st St. Wash. D.C.		24a. REC'D BY REGISTRAR DATE DEC 7 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		DATE OF DEATH _____	
TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____			
MANNER OF DEATH <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NATURAL			
SIGNATURE OF MEDICAL EXAMINER _____			
DATE OF SIGNATURE _____			



This certificate is to be filled out by the Medical Examiner of the State of Maryland, and is to be filed in the office of the State Department of Health, Baltimore, Maryland. It is to be used in the event of a death occurring in the State of Maryland, and is to be filled out by the Medical Examiner of the State of Maryland, and is to be filed in the office of the State Department of Health, Baltimore, Maryland.

14119

CERTIFICATE OF DEATH

Reg. Dist. No.

14073

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hght.		c. LENGTH OF STAY IN lb 4 1/2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5041--Dunlap St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCIS Middle F. Last PRATHER		4. DATE OF DEATH Month Dec. Day 17th Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1923
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Creditor Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Gulf Discount Corp.	
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James R. Prather		14. MOTHER'S MAIDEN NAME Jane Cowan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
INFORMANT Jane B. Prather-Wife		Address 5041--Dunlap St., SE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Two previous myocardial infarctions			INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 56 , to Nov. , 19 59 , that I last saw the deceased alive on Nov. 24 , 19 59 , and that death occurred at 4437 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward J. Pacious M.D.		ADDRESS (Street, city or town, state) 1746 K St. N.W. Wash. D.C.	
DATE SIGNED 1746--K. St., N.W. Wash. DC			
PHYSICIAN'S NAME (Type) Dr. Ed J. Pacious			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-21-59	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl.	22d. LOCATION (City, town, or county) (State) Arlington Va
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		24a. REC'D BY REGISTRAR DATE DEC 21 '59	
ADDRESS 1661--Good Hope Rd., SE Wash. 20, DC		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAINTENANCE STATEMENT OF WORK - BAYVIEW OF
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14120

CERTIFICATE OF DEATH

Reg. Dist. No.

14074

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Dist. of Columbia COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Glenn Dale)		c. LENGTH OF STAY IN lb 57 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Prettyman Last Prettyman		4. DATE OF DEATH Month December Day 25 Year 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1890
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 20 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John A. Prettyman	
14. MOTHER'S MAIDEN NAME Ella Jones		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Unknown		INFORMANT Person	
17. ADDRESS Person		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis, Far Advanced 002X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bullous Emphysema; Cor pulmonale with Congestive failure, compensated	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 10/30 , 19 59 , to 12/25 , 19 59 , that I last saw the deceased alive on 12/25 , 19 59 , and that death occurred at 12:15 PM , from the causes and on the date stated above.	
ACTUAL SIGNATURE Moe Weiss		DATE SIGNED 12/25/59	
PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		ADDRESS (Street, city or town, state) Glenn Dale Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Sullivan Sons		24a. REC'D BY REGISTRAR DEC 30 '59	
ADDRESS 1756 Penna. Ave., Wash., D.C.		24b. REGISTRAR'S SIGNATURE Charles S. Harris	

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VS A15 (4)
15M 9/58

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10130

OPTICATE IN DEATH

WARRANT STATE OF ARIZONA - BATHROOM 121

10130

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14075

14081

Item 7 Film G253 12-16-59 et

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 hrsn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Princes Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah C Reeves		4. DATE OF DEATH Dec. 7 19 59	
5. SEX Negro-Fm.	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-80
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary M. Jones Aquasco ind		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pulmonary Embolism 142.0 DUE TO Thrombosis of rt. Femoral vein Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Parotid Gland DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED 12-9-59	
EXAMINER'S NAME (Type) Dr. John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 12/12/59	22c. NAME OF CEMETERY OR CREMATORY John Wesley	22d. LOCATION (City, town, or county) (State) Aquasco, Prince Georges, Md
23. FUNERAL DIRECTOR'S SIGNATURE George A. Nelson		24a. REC'D BY REGISTRAR DEC 10 '59	
		24b. REGISTRAR'S SIGNATURE William S. Thomas	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

14082

CERTIFICATE OF DEATH

Reg. Dist. No.

14076

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince /Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 1204-54th Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julia Middle B. Last Rhodes				4. DATE OF DEATH Month Dec. Day 8 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-13-13	
9. AGE (In years lost birthday) 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		11. BIRTHPLACE (State or foreign country) New York, N.Y		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Gustav Ey.				14. MOTHER'S MAIDEN NAME Augusta Michael			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I				16. SOCIAL SECURITY NO. 577-01-2689			
17. INFORMANT Address John T Rhodoc -same as above							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leucytopemia - Chronic 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Ch. Myelogenous Leukemia DUE TO (c) 2 yrs.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1 , 19 57 , to 12-8 , 19 59 that I last saw the deceased alive on 12-8 , 19 59 , and that death occurred at 12:18 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George Hageage M.D.				ADDRESS (Street, city or town, state) 3717-38th Le DATE SIGNED 12-8-59			
PHYSICIAN'S NAME (Type) Dr. George Hageage							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft Myer. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D. C.				24a. REC'D BY REGISTRAR DATE DEC 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14082

1

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of attending physician: _____

10. Signature of medical examiner: _____

11. Signature of registrar: _____

12. Date of filing: _____

13. File number: _____

14. Remarks: _____

1

CERTIFICATE OF DEATH

Reg. Dist. No.

14077

14083

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 yrs -	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARENCE First C. Middle RINGGOLD Last		4. DATE OF DEATH Month 12 Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26 - 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Kent Island Queen Anne's Co. Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James B Ringgold		14. MOTHER'S MAIDEN NAME Mary Elizabeth Nelson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Elizabeth R Storey Landover Hills, Md		Address 6311 Annapolis Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC CONGESTIVE HEART FAILURE 420.0 DUE TO Coronary Sclerosis of Aorta & Pericard. Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 11-15-1959 to 12-27-1959 that I last saw the deceased alive on 12-27-1959 , and that death occurred at 12:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert Roth		ADDRESS (Street, city or town, state) RIVERDALE, Md	
PHYSICIAN'S NAME (Type) Dr. Albert Roth		DATE SIGNED 12-27-59	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 30-59	
22c. NAME OF CEMETERY OR CREMATORY Stonemille		22d. LOCATION (City, town, or county) (State) Stonemille Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE James H. Baiter of Baiter Bros., Centerville, Md		24a. REC'D BY REGISTRAR DATE JAN 5 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1903

County of Suffolk, State of Massachusetts

Town of Boston

Ward of South Boston

City of Boston

Dec 10 1903

1903

Age 45

Male

Single

Occupation of Deceased

James J. Connelley

Residence of Deceased

No. 10

St.

Place of Death

No. 10

St.

Cause of Death

No. 10

St.

Signature of Physician

No. 10

St.

Signature of Registrar

No. 10

St.

Signature of Coroner

No. 10

St.

Signature of Minister

No. 10

St.

Signature of Justice

No. 10

St.

Signature of Notary

No. 10

St.

Signature of Deceased

No. 10

St.

Signature of Witness

No. 10

St.

Signature of Deceased

No. 10

St.

Signature of Witness

No. 10

St.

Signature of Deceased

No. 10

St.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14121
CERTIFICATE OF DEATH

14078

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON (Rural)</u>		c. LENGTH OF STAY IN 1b <u>23 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SO. MARYLAND HOSPITAL CENTER</u>				d. STREET ADDRESS <u>Rt 2 Box 342</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORBAN HAMILTON RUDY</u>				4. DATE OF DEATH Month Day Year <u>December 25 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 1 1890</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Rudy</u>				14. MOTHER'S MAIDEN NAME <u>Alta Schindler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Nov 1918-1919</u>		16. SOCIAL SECURITY NO. <u>206-40-6466</u>		INFORMANT <u>wife-</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>approx 30 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 24th</u> , 19 <u>59</u> , to <u>Dec 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 25th</u> , 19 <u>59</u> , and that death occurred at <u>7:50 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David N. Rohl</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Dec 25 1959</u>			
PHYSICIAN'S NAME (Type) <u>Clinton, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Columbia Manor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee - Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kanda</u>	

CERTIFICATE OF DEATH

1911

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14122

CERTIFICATE OF DEATH

Reg. Dist. No.

14079

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY COLUMBIA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS 4234 6th STREET S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOVE Middle ---- Last RYAN				4. DATE OF DEATH Month DECEMBER Day 5 Year 1959			
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 DECEMBER 1959	
9. AGE (In years last birthday) 1		10. IF UNDER 1 YEAR Months 1 Days 4 Hours 40		11. IF UNDER 24 HRS. Min. 40			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES							
13. FATHER'S NAME RONALD HARVEY RYAN				14. MOTHER'S MAIDEN NAME JERILYN STONE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A				16. SOCIAL SECURITY NO. N/A		INFORMANT CHART	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) PREMATURITY DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 DAY			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 DECEMBER, 1959 to 5 DECEMBER, 1959 , that I last saw the deceased alive on 5 DECEMBER, 1959 , and that death occurred at 1:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arnold A. Abramo				ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS		DATE SIGNED 5 DEC 59	
PHYSICIAN'S NAME (Type) ARNOLD A ABRAMO CAPT USAF MC				USAF HOSPITAL ANDREWS, ANDREWS AFB, WASH 25			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Not given		22c. NAME OF CEMETERY OR CREMATORY District Morgue		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE ----				ADDRESS ----		24a. RECEIVED BY REGISTRAR DATE DEC 10 59	
				24b. REGISTRAR'S SIGNATURE Arthur J. Flanagan			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050171XVI

2

1

NEW YORK

Blank form area for the Certificate of Death, containing faint horizontal lines for text entry.

14084

CERTIFICATE OF DEATH

Reg. Dist. No.

14080

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 29 Hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Paul First Paul Middle Julius Last Savoy		4. DATE OF DEATH Month Dec. Day 12 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11
9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months 29 Days 29 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Paul Clements Procter		14. MOTHER'S MAIDEN NAME Mary Louise Savoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 11 , 59 , to Dec. 12 , 19 59 that I last saw the deceased alive on Dec. 12 , 19 59 , and that death occurred at 8 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Bertha G Van Gelderen M.D.		ADDRESS (Street, city or town, state) 3001 Cheverly Ave. Cheverly, Md. DATE SIGNED	
PHYSICIAN'S NAME (Type) Bertha G Van Gelderen., M.D.		3001 Cheverly Ave. Cheverly., Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 15, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DEC 21 '59 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1008222XU0

CERTIFICATE OF DEATH

1908

Name of deceased _____ Sex _____ Age _____

Place of birth _____ Date of birth _____

Usual residence _____

Occupation _____

Married _____

Signature of physician _____

Signature of registrar _____

Signature of informant _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

Signature of witness _____

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14085

Item 7 Film 9253 12-21-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>10 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Southland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				f. STREET ADDRESS <u>14601 - Lewis Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>Schaefer</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9, 1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Health Dept</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William John Schaefer</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Butterworth Fier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>577-44-5518</u>		17. INFORMANT <u>Gladys A. Helman</u> Address <u>4109 - 4th St</u> <u>Southland, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-12-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ogan</u>				ADDRESS <u>317 Park Ave S.E. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-082

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERVIEW	
22. SIGNATURE OF INTERVIEW		23. SIGNATURE OF INTERVIEW		24. SIGNATURE OF INTERVIEW	
25. SIGNATURE OF INTERVIEW		26. SIGNATURE OF INTERVIEW		27. SIGNATURE OF INTERVIEW	
28. SIGNATURE OF INTERVIEW		29. SIGNATURE OF INTERVIEW		30. SIGNATURE OF INTERVIEW	
31. SIGNATURE OF INTERVIEW		32. SIGNATURE OF INTERVIEW		33. SIGNATURE OF INTERVIEW	
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46. SIGNATURE OF INTERVIEW		47. SIGNATURE OF INTERVIEW		48. SIGNATURE OF INTERVIEW	
49. SIGNATURE OF INTERVIEW		50. SIGNATURE OF INTERVIEW		51. SIGNATURE OF INTERVIEW	
52. SIGNATURE OF INTERVIEW		53. SIGNATURE OF INTERVIEW		54. SIGNATURE OF INTERVIEW	
55. SIGNATURE OF INTERVIEW		56. SIGNATURE OF INTERVIEW		57. SIGNATURE OF INTERVIEW	
58. SIGNATURE OF INTERVIEW		59. SIGNATURE OF INTERVIEW		60. SIGNATURE OF INTERVIEW	
61. SIGNATURE OF INTERVIEW		62. SIGNATURE OF INTERVIEW		63. SIGNATURE OF INTERVIEW	
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97. SIGNATURE OF INTERVIEW		98. SIGNATURE OF INTERVIEW		99. SIGNATURE OF INTERVIEW	
100. SIGNATURE OF INTERVIEW		101. SIGNATURE OF INTERVIEW		102. SIGNATURE OF INTERVIEW	

RECEIVED
BALTIMORE
MAY 10 1908

14086

CERTIFICATE OF DEATH

Reg. Dist. No.

14082

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princes Georgesz Cheverly				c. LENGTH OF STAY IN 1b 12 hrs X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Princes Georges General Hospital				d. STREET ADDRESS Rt 1 Box 158		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Slater				4. DATE OF DEATH Month Day Year Dec. 7 1959			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1959	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Franklin ALEXANDER				14. MOTHER'S MAIDEN NAME Doris ROSALIE YOUNG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. MOTHER Box 158 Rt. 1 AQUASCO			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 7, 1959 to Dec 7, 1959 that I last saw the deceased alive on Dec. 7, 1959 , and that death occurred at 10:00 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Burtha S. Hays, M.D.				ADDRESS (Street, city or town, state) 3001 Annapolis Ave Cheverly Md			
PHYSICIAN'S NAME (Type) Burtha S. Hays				DATE SIGNED 12/8/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 12/16/59		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn Jr.				24a. REC'D BY REGISTRAR DEC 21 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hays	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G254 1-4-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

14083

14087

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 15 Min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City d. STREET ADDRESS 4014 Parkwood St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Souder First Middle Last		4. DATE OF DEATH Dec. 27 19 59 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1878
9. AGE (In years last birthday) 81 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WASH D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph A Souder		14. MOTHER'S MAIDEN NAME DORA C. Reckeweg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-34-4152	
17. INFORMANT ABBBIE E. Souder		Address BRENTWOOD 7A.D. 4014 PARKWOOD ST	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO coronary occ curam Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) arteriovascular heart disease DUE TO year (c)		INTERVAL BETWEEN ONSET AND DEATH about	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 27th , 19 59 , to Dec 27th , 19 59 , that I last saw the deceased alive on Dec 27th , 19 59 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4314 Federal St Hyge Md May Land			
ACTUAL SIGNATURE Til Bergman		PHYSICIAN'S NAME (Type) Dr. Til Bergman, M.D.	
22a. BURIAL, CREMATION, or other disposition REMOVED		22b. DATE THEREOF 12/30/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 44 West Ave NE		24a. REC'D BY REGISTRAR DATE DEC 29 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

14087

Joseph A. Golden

No. 20-1-10000

Dear C. H. H. H. H.

Very truly yours,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Item 18 Film 254 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1-5-60 ams 14123 Item 2 Film G254 1-4-60 at CERTIFICATE OF DEATH										14084	
										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND D.C. COUNTY PRINCE GEORGES						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs					c. LENGTH OF STAY IN 1b 2 hrs 14 mins		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 4TX-3				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews AFB					d. STREET ADDRESS 3865 Halley Terr. S.E. 1 ANDREWS AFB WASH. D.C.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SUSAN K. Staten					4. DATE OF DEATH December 25 19 59						
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 Dec. 1959		9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James R. Staten					14. MOTHER'S MAIDEN NAME THEOA K. PALMER						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Hospital Records Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 560.4 DUE TO Atelectasis, congenital Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diaphragmatic hernia (c) 14 minutes INTERVAL BETWEEN ONSET AND DEATH two hours and 14 minutes										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 25 DEC., 1959, to 25 DEC., 1959, that I last saw the deceased alive on 25 DECEMBER 1959, and that death occurred at 5:32 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE John A. Moore M.D. USAF HOSPITAL ANDREWS ANDREWS AFB WASH. D.C. 25 DEC 59											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/29/59		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State) Byesville, Ohio		
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home Washington 2, D. C.						24a. REC'D BY REGISTRAR DATE DEC 28 '59		24b. REGISTRAR'S SIGNATURE Corina S. Krawa			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1408 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u> c. LENGTH OF STAY IN 1b <u>2 1/2 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Hall</u> d. STREET ADDRESS <u>Boyce Farm</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Kirk Douglas Stevens</u>			4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1955</u>										
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-58</u>		9. AGE (In years last birthday) <u>1</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>									
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Arthur J. Stevens</u>										
14. MOTHER'S MAIDEN NAME <u>Lavinia Johnson</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>										
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Arthur J. Stevens; same address</u>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>790.1 Acute Inanition</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)		(County)		(State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>John F. Maloney</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>										
EXAMINER'S NAME (Type) <u>John F. Maloney, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>DEC-23-1959</u>			DATE SIGNED										
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Dec. 26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's Catholic</u>									
22d. LOCATION (City, town, or county) <u>Prince Georges</u>		(State) <u>Md</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Johnson</u>			ADDRESS <u>Armaples</u>										
24a. REC'D BY REGISTRAR <u>DEC 29 '59</u>			24b. REGISTRAR'S SIGNATURE <u>Carlton B. H.</u>										

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14124

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14086

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>		
c. LENGTH OF STAY IN 1b <u>6 days</u>			d. STREET ADDRESS <u>5408 - Henderson Rd</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suitland Nursing Home</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Stoner</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1959</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Aug 6, 1878</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Cyrus Stoner</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Brockers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Walcott W Gibson</u> Address <u>Amesboro #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrothrombosis</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>James I. Boyd</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>Dec 26, 1959</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Dec 30 - 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Knoxville Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Attie - Indiana</u>		(State)		24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Sellers</u>		ADDRESS <u>254 Central St</u>		24b. REGISTRAR'S SIGNATURE <u>James I. Boyd</u>	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
TIME OF DEATH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		TREATMENT _____	
PHYSICIAN'S SIGNATURE _____		MEDICAL EXAMINER'S SIGNATURE _____	
DATE OF SIGNATURE _____		DATE OF SIGNATURE _____	

1

CERTIFICATE OF DEATH

Reg. Dist. No.

14088

14125

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S CO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND by COUNTY PRINCE GEORGE'S CO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill Md		c. LENGTH OF STAY IN 1b 71 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4931-LIVINGSTON ROAD S.E.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George HERBERT TALBERT SR		4. DATE OF DEATH Month Day Year Dec. 8th 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 5-1880 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY FARMER	
11. BIRTHPLACE (State or foreign country) Oxon Hill Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JONATHAN P. TALBERT		14. MOTHER'S MAIDEN NAME ANNIE E CisseL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. SALLIE ANN TALBERT #2	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 58 to Dec 8 59 , that I last saw the deceased alive on Dec 8 59 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert W. Wisotzky		ADDRESS (Street, city or town, state) DATE SIGNED 101 Sudley Lane SE 12/8/59 Wash 2110	
PHYSICIAN'S NAME (Type) HERBERT WISOTZKY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 11-59	22c. NAME OF CEMETERY OR CREMATORY Washington National	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Sumner Brothers 1661-gd Pope Rd SE		24a. REC'D BY REGISTRAR DATE DEC 10 59	
24b. REGISTRAR'S SIGNATURE Carlton S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14089

FOR STATE
HEALTH DEPT.

14126

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosaryville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosaryville (Rural)	
c. LENGTH OF STAY IN 1b Life		d. STREET ADDRESS Route # 1, Upper Marlboro, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 1, Upper Marlboro		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE THOMAS TAYLOR		4. DATE OF DEATH Month December Day 25th , Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7th, 1879
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Prince Georges Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Marshall Taylor		14. MOTHER'S MAIDEN NAME Mary Ellen Cater	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Maria E. Peters, 602--A--St., N.E. Wash. D.C.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Universal burns of the body (a), stating the underlying cause last. (c) second and third degree PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was in room that caught on fire	
20c. TIME OF INJURY Month, Day, Year 12-25-59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. CITY or town Rosaryville P.G. Co. Md
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED 12/26/1959	
EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/29/1959	22c. NAME OF CEMETERY OR CREMATORY St. Thomas Church Cem.	22d. LOCATION (City, town, or county) (State) Croom, Pr. Geo. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Company, 517--11th St. S.E. Wash. DC		24a. REC'D BY REGISTRAR DATE DEC 29 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11122

MAKED AND STATE DEPARTMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

SEX

EDUCATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

EDUCATION

SEX

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CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

EDUCATION

SEX

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

SEX

EDUCATION

CAUSE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G253 12-14-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

14090

14089

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beverly		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lakeland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital			d. STREET ADDRESS 8113 54th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Andrew Middle Thomas Last Thomas			4. DATE OF DEATH Month Dec. Day 1 Year 1959		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1888	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Dept. of Agriculture		11. BIRTHPLACE (State or foreign country) Laurel, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Andrew Thomas		
14. MOTHER'S MAIDEN NAME Hilce Hebron			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		
16. SOCIAL SECURITY NO. INFORMANT			Address Merrill Thomas - 4902 Lakeland Rd.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c) Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Encephalomalacia 2. Bronchopneumonia					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 11-29- , 19 59 , to 12-1 , 19 59 that I last saw the deceased alive on Dec. 1, 1959 , and that death occurred 9:25 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Til Bergman		ADDRESS (Street, city or town, state) 4319 Seale St 1		DATE SIGNED Dec 1 1959	
PHYSICIAN'S NAME (Type) Dr. Til Bergman, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Dec. 6 1959		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY 1500 N. 1st St. N. Ch. Cem.	
22d. LOCATION (City, town, or county) Bacon, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Washington		ADDRESS 467 N. W. 1st St.		24a. REC'D BY REGISTRAR DATE DEC 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Frame					

CERTIFICATE OF DEATH

1989

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14090

14091

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 37 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charlotte Middle D Last Thomas				4. DATE OF DEATH Month Dec. 5 Day 15 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 18, 1876	
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Rev J H Dudley				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT George Thomas		Address same as no 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 585x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) choleangiolytic disease DUE TO (c) obstructive jaundice						INTERVAL BETWEEN ONSET AND DEATH Oct 1-59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1 , 19 59 , to Dec 5 , 19 59 , that I last saw the deceased alive on Dec 5 , 19 59 , and that death occurred at 8:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE George Hageage				ADDRESS (Street, city or town, state) Cottage City Md.			
PHYSICIAN'S NAME (Type) Dr. Geo. Hageage, M.D.				DATE 12-5-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 7, 1959		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE DEC 9 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

M

077

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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Reg. Dist. No.

14092

14020

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Mt. Rainier</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3306 - Otis Street</u>				d. STREET ADDRESS <u>13306 Otis Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Sharpe</u> Last <u>Tompkins</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>27 Sept. 1885</u>		9. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (State or foreign country) <u>Highland N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Henry Tompkins</u>				14. MOTHER'S MAIDEN NAME <u>Adeline Hoxie Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>578-09-0070</u>		17. INFORMANT Address <u>3306 Otis St.</u> <u>Clara E. Manderschied</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma lung mediastinal area</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heavy cigarette smoker for years</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>6 Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3 Dec</u> , 19 <u>59</u> , and that death occurred at <u>7:29</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James O. Mattingly, M.D.</u>				ADDRESS (Street, city or town, state) <u>2200 R. I. Ave N.E. 18</u>			
PHYSICIAN'S NAME (Type) <u>Thomas E. Mattingly, M.D.</u>				DATE SIGNED <u>6 Dec 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u>				ADDRESS <u>Mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 10 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			

MEDICAL CERTIFICATION

14093

Reg. Dist. No.

HOSPITAL [redacted] **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. (DISTRICT OF COLUMBIA) P.D.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 27, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		d. STREET ADDRESS 6229 MARLBORO PIKE	
3. NAME OF DECEASED (Type or print) First Middle Last LAURENCE LEE THOMPSON JR		4. DATE OF DEATH Month Day Year DECEMBER 3 1959	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 NOVEMBER 1959
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months Days Hours Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME LAURENCE LEE THOMPSON		14. MOTHER'S MAIDEN NAME SUSAN O'ROURKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT Address CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PREMATURITY DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES 3 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 DECEMBER, 1959, to 3 DECEMBER, 1959, that I last saw the deceased alive on 3 DECEMBER, 1959, and that death occurred at 0040A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>Reginald P McManus</i> M.D.		USAF HOSPITAL ANDREWS 3 DEC 59	
PHYSICIAN'S NAME (Type) REGINALD P MCMANUS CAPT USAF MC USAF HOSP ANDREWS, ANDREWS AFB, Wash 25 D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/8/59	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE <i>Michael J. Rinaldi</i>		24a. REC'D BY REGISTRAR DATE DEC 7 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
816 H Street, N. E. Washington 2, D. C.			

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CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14094

14091

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Col. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp.			d. STREET ADDRESS 230 Rhode Island Ave. N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Lee D Totman			4. DATE OF DEATH Month December 24, Year 19 59		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1876		9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired salesman		10b. KIND OF BUSINESS OR INDUSTRY Produce		11. BIRTHPLACE (State or foreign country) California	
13. FATHER'S NAME John Totman		14. MOTHER'S MAIDEN NAME Charolett Foster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Miss Ariel F. Totman Washington D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Surgical procedure for resection of colon (c) Carcinoma of the colon					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John J. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		December 25, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/26/59		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1001

See 1001.11

Age of Deceased

Sex

Place of Birth

Residence

Occupation

Date

Time of Death

Place of Death

Medical History

Findings

Diagnosis

Signature

Witness

Coroner

Remarks

Signature

Signature of Medical Examiner

Signature

Signature of Coroner

Signature of Coroner

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Signature of Coroner

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Signature of Coroner

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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14128

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14095

1. PLACE OF DEATH a. COUNTY <u>PRINCE Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXON Hill</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4911-FOREST DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE-MARTHA-TUCKER</u>		4. DATE OF DEATH Month Day Year <u>DEC 15 19 59</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 16-1880</u>
9. AGE (In years last birthday) yrs. <u>79</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
13. FATHER'S NAME <u>John WROTEN</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA ELLIOTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE.</u>	
17. INFORMANT <u>STELLA DAVIS</u>		Address <u>4911 FOREST DR. OXON HILL MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 11</u> , 19 <u>59</u> , to <u>Dec 15</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>59</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>5664 LIVINGSTON ROAD</u> ACTUAL SIGNATURE <u>Edwin C. Lane</u> M.D. PHYSICIAN'S NAME (Type) <u>EDWIN C. LANE M.D.</u> <u>OXON HILL MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 18-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Tucker Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tucker Dale, N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>SIMMONS BROS</u>		ADDRESS <u>1661 GOOD HOPE WASH. D.C.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

1918

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CERTIFICATE OF DEATH

Reg. Dist. No.

14096

14092

1. PLACE OF DEATH a. COUNTY Prince George				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 21 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frances Vest				4. DATE OF DEATH Month Day Year Dec. 7 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1912	
9. AGE (In years and months) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) WHITE STONE VA	
13. FATHER'S NAME RICHARD F DIX				14. MOTHER'S MAIDEN NAME GLADYS POWELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT Address ISAAC M VEST SAME AS ITEM 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic melanoma 190.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant melanoma DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 month 13 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 19				20g. (County) 19		20h. (State) 19	
21. I certify that I attended the deceased from July , 19 56 , to Dec. 7 , 19 59 , that I last saw the deceased alive on Dec. 7 , 19 59 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon R. Leviksy M.D.				ADDRESS (Street, city or town, state) 3408 Rhode Island Ave NW, Washington, D.C.			
PHYSICIAN'S NAME (Type) Dr. Leon R. Leviksy M.D.				DATE SIGNED 12/7/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-10-59		22c. NAME OF CEMETERY OR CREMATORY FT LINCOLN CEM		22d. LOCATION (City, town, or county) (State) BLADENSBURG MD	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co				ADDRESS 5801 Cleveland Ave		24a. REC'D BY REGISTRAR DEC 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14129

CERTIFICATE OF DEATH

Reg. Dist. No.

14097

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi, Md. 2 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Mt. Rainier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Saint Branch Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Caroline Watts</u>		4. DATE OF DEATH <u>Dec. 9 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1869</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Alexandria, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James W. Nichols</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Faulkner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1 1959</u> to <u>Dec 9 1959</u> , that I last saw the deceased alive on <u>Dec 6 1959</u> , and that death occurred at <u>7:20 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock M.D.</u>		ADDRESS (Street, city or town, state) <u>2701 Carroll Ave</u> DATE SIGNED <u>12-9-59</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>		<u>Theresa Park, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/12/59</u>	22c. NAME OF CEMETERY OR CREMATOR <u>Nichols Memorial Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Odenton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home Inc.</u>		24a. REG'D BY REGISTRAR <u>DEC 14 '59</u>	
ADDRESS <u>Mt. Rainier, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 14093 CERTIFICATE OF DEATH

Reg. Dist. No. 14098

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Carl C Weyforth				4. DATE OF DEATH Month Day Year Dec. 17 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 25, 1888	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Musician		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Robert Weyforth				14. MOTHER'S MAIDEN NAME Elizabeth Holecek			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Hospital record				Address Washington D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 586x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) cholesterol crystals PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 10th , 19 57 , to Dec. 17 , 19 59 that I last saw the deceased alive on Dec 17th , 19 59 , and that death occurred at 1:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3-D Crescent Road DATE SIGNED ACTUAL SIGNATURE Til Bergman M.D. PHYSICIAN'S NAME (Type) Dr. Til Bergman Green belt, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF Dec 19, 1959			
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory				22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.			
24a. REC'D BY REGISTRAR DEC 23 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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CERTIFICATE OF DEATH

Reg. Dist. No. 14099

14130

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 328 6th St., S. E.	
3. NAME OF DECEASED (Type or print) First Sarah Middle E. Last Whitehead		4. DATE OF DEATH Month 12 Day 20 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/7/1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John K. Bailey		14. MOTHER'S MAIDEN NAME Ada Grimes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Decedent		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 yrs.,
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/6/ 1956 to 12/20 1959 , that I last saw the deceased alive on 12/20 19 59 , and that death occurred at 3:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 12/20/59 ACTUAL SIGNATURE Moe Weiss M.D. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL, (Specify) BURIAL	22b. DATE THEREOF 12-22-59	22c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Michael L. Lualaba		24a. REC'D BY REGISTRAR DATE DEC 24 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-10-19

CERTIFICATE OF SALE

1180



[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a formal document, possibly a certificate of sale or a legal record, containing several lines of text and possibly a signature area at the bottom.]



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14100

Reg. Dist. No.

14131

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Suitland</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4715 1/2 Summer Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Suitland</u> d. STREET ADDRESS <u>14715 1/2 Summer</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Hughes Williams</u> 4. DATE OF DEATH Month Day Year <u>Dec 13 1959</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Dec 11, 1883</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Skilled Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Railway Express</u> 11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>				13. FATHER'S NAME <u>John D. Williams</u> 14. MOTHER'S MAIDEN NAME <u>Irene Cooper Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Mrs Elizabeth Williams same as #7</u> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input "="" checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE <u>James I. Boyd</u> EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec 13, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>12/16/59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> 22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Jr. Dec 5 1959</u> ADDRESS <u>517 11th St. S.E.</u> 24a. REC'D BY REGISTRAR <u>Dec 17 '59</u> 24b. REGISTRAR'S SIGNATURE <u>C. S. Frank</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 68		4. RACE White	
5. DATE OF DEATH Jan 15, 1954		6. TIME OF DEATH 10:30 AM	
7. PLACE OF DEATH Home		8. STREET ADDRESS 1234 N. E. St.	
9. CITY OR TOWN Baltimore		10. COUNTY Baltimore	
11. OCCUPATION Retired			
12. MARITAL STATUS Married			
13. NAME OF SPOUSE Mary H. Harris			
14. NAME OF NEXT OF KIN John H. Harris			
15. NAME OF PHYSICIAN Dr. J. H. Harris			
16. NAME OF HOSPITAL None			
17. NAME OF NURSING HOME None			
18. NAME OF FUNERAL HOME J. H. Harris			
19. NAME OF BURIAL PLACE None			
20. NAME OF CEMETERY None			
21. NAME OF INTERMENT None			
22. NAME OF CREMATION None			
23. NAME OF OTHER DISPOSITION None			
24. NAME OF OTHER DISPOSITION None			
25. NAME OF OTHER DISPOSITION None			
26. NAME OF OTHER DISPOSITION None			
27. NAME OF OTHER DISPOSITION None			
28. NAME OF OTHER DISPOSITION None			
29. NAME OF OTHER DISPOSITION None			
30. NAME OF OTHER DISPOSITION None			
31. NAME OF OTHER DISPOSITION None			
32. NAME OF OTHER DISPOSITION None			
33. NAME OF OTHER DISPOSITION None			
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37. NAME OF OTHER DISPOSITION None			
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39. NAME OF OTHER DISPOSITION None			
40. NAME OF OTHER DISPOSITION None			
41. NAME OF OTHER DISPOSITION None			
42. NAME OF OTHER DISPOSITION None			
43. NAME OF OTHER DISPOSITION None			
44. NAME OF OTHER DISPOSITION None			
45. NAME OF OTHER DISPOSITION None			
46. NAME OF OTHER DISPOSITION None			
47. NAME OF OTHER DISPOSITION None			
48. NAME OF OTHER DISPOSITION None			
49. NAME OF OTHER DISPOSITION None			
50. NAME OF OTHER DISPOSITION None			

14094

CERTIFICATE OF DEATH

Reg. Dist. No.

14101

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Uneverly</u>		c. LENGTH OF STAY IN 1b <u>1 Month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>M</u> Last <u>Wallis</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>26</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 9, 1875</u>
9. AGE (In years lost birthday) yrs. <u>84</u>		10. IF UNDER 1 YEAR Months <u>84</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD BRAHLER</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE DONOHUE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-48-5894</u>	
17. INFORMANT <u>MRS. THELMA GRANE</u>		Address <u>9511-SHERIDAN ST SEABROOK ACRES MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombosis of right auricular appendage</u> DUE TO (c) <u>Auricular fibrillation</u> 1 month PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 26</u> , 19 <u>59</u> , to <u>Dec. 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 26</u> , 19 <u>59</u> , and that death occurred at <u>2:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Til Bergman</u>		ADDRESS (Street, city or town, state) <u>3 D Cresent Rd Greenbelt, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Til Bergman, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) - <u>12/30/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Phelaffell</u>		ADDRESS <u>475-H-7th St</u>	
24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

in the case of the
the following:

14095

CERTIFICATE OF DEATH

Reg. Dist. No.

14102

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington - D.C.</u> b. COUNTY <u>47X-3</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington - D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mattie C. Wilson</u>		4. DATE OF DEATH <u>Dec. 25 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1878</u>
9. AGE (In years last birthday) <u>81</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Graniteville - S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John H. Coursey</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Congestive Heart Failure</u> DUE TO (b) <u>Auricular Fibrillation</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>over 3 yrs. Many yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 24</u> , 19 <u>56</u> , to <u>Dec. 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 23</u> , 19 <u>59</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jesse C. Coggins</u> M.D.		ADDRESS (Street, city or town, state) <u>Laurel Sanitarium</u> DATE SIGNED <u>12/25/59</u>	
PHYSICIAN'S NAME (Type) <u>Jesse C. Coggins - M.D.</u>		<u>Laurel - Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>	
ADDRESS <u>2901-14th St. N.W. Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14132

CERTIFICATE OF DEATH

Reg. Dist. No.

14103

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. LENGTH OF STAY IN 1b 11 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) USAF HOSPITAL ANDREWS				d. STREET ADDRESS 607 BRANDYWINE STREET, SE			
3. NAME OF DECEASED (Type or print) First MARGARET Middle B Last YESULAITIS				4. DATE OF DEATH Month DECEMBER Day 15 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 SEPTEMBER 1882		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) LITHUANIA-RUSSIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME JOHN BALANDA				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or date of service] NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT JOHN F YESULAITIS (SON) Address 706 BRANDYWINE STREET, WASHINGTON, DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE WITH INFARCTION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 20 YEARS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 DECEMBER 1959 , to 15 DECEMBER 1959 , that I last saw the deceased alive on 15 DECEMBER 1959 , and that death occurred at 0200 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>John F. Bridgeman</i> M.D. USAF HOSPITAL ANDREWS				15 DECEMBER 59			
PHYSICIAN'S NAME (Type) JOHN F BRIDGEMAN, CAPT, USAF, MC				USAF HOSPITAL ANDREWS, WASHINGTON 25, DC			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12-19-59		St Josephs		Summit Hill Pa	
23. FUNERAL DIRECTOR'S SIGNATURE R. Mattingly, 131 - 11th St., S.E.				24a. REC'D BY REGISTRAR DATE DEC 18 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Page 4
death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14096

Items 11 & 12 Film G253 12/24/59 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

14104

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Arthur Young		4. DATE OF DEATH Month Day Year Dec. 14 1959	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 June 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Young		14. MOTHER'S MAIDEN NAME Pricilla	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mary Young 7137 Whitehouse Rd. Ritchie, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 610X DUE TO Chemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Acute pyelonephritis with abscess formation DUE TO Prostatic hypertrophy		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-14 , 19 59 , to 12-14 , 19 59 that I last saw the deceased alive on 12-14 , 19 59 , and that death occurred at 5.00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James B. Backrach M.D.		ADDRESS (Street, city or town, state) 915 - 19th St. N.W. Wash. DC. 12/14/59	
DATE SIGNED 12/14/59		DATE SIGNED 12/14/59	
PHYSICIAN'S NAME (Type) Louis B. Backrach, M.D.		ADDRESS 915 - 19th Street, N.W. Washington, D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/19/59	
22c. NAME OF CEMETERY OR CREMATORY St. Simon		22d. LOCATION (City, town, or county) (State) Croome, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Stewart #3081 St. NE		ADDRESS St. NE	
24a. REC'D BY REGISTRAR DEC 17 '59		24b. REGISTRAR'S SIGNATURE C. S. Hines	

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